Appendix C: Long-Term Care Issues Identified by State Ombudsmen - 1999 to 2001

About this chart: The issues which states addressed in their reports are grouped by seven general categories: **Access to Facilities and Services, Enforcement, Environment, Staffing, Patient Care, Residents' Rights and Ombudsman Program Issues**. Subcategories of these general issues, and even some subgroups of subcategories, are in the left column; states which identified the particular issue are in the second column, and descriptions of the problem, barriers to resolution and action(s) the Ombudsman Program (state, regional, or local) has taken or recommendations to resolve the issue are in the long third column. Most descriptions are tightly edited paraphrases. There is much interrelationship between the various issues. For example, **staffing** is directly related to **resident care**; **transfer/discharge** is both an access and a **residents' rights** issue; consequently, a state's discussion of an issue under one heading may be partially repeated under another issue. Some standard abbreviations are used in the text throughout: Adult Care Home (ACH), Adult Care Facility (ACF), Adult Protective Services (APS),Assisted Living Facility (ALF), Board and Care (B&C), Certified Nursing Assistant (CNA), Mental Health (MH), Mental Retardation (MR), long term care (LTC), LTC Ombudsmen (LTCO), LTCO Program (LTCOP), personal care home or personal care boarding home (PCH), nursing facility (NF), nursing home (NH), Registered Nurse (RN), Residential Care Facility (RCF)

General Issue: Access to Facilities and Services		
Transfer and Discharge		
Assisted Living, B&C, Similar	**AZ**	**2001** The priority issue was inappropriate discharge. Most discharge issues were resolved by talking with the facility to assure proper and safe discharge.
	MD	**2001** Issues in these facilities include inappropriate discharges.
	NC	**1999** Individuals discharged because they voiced complaints/asserted rights or staff viewed them as a nuisance. Lack of regulation or policy regarding discharge rights in ACHs; industry opposition to regulations; licensure agency unwilling to address certain discharges as retribution for complaints under residents' rights. **Action:** Worked with advocacy agencies/groups, the federal government to secure passage of a law giving ACH residents the same transfer/discharge rights as NH residents. **2000** Multiple complaints regarding ACHs inappropriately discharging residents. Industry opposition, industry and regulatory agencies not educated on new transfer/discharge law/regulation entitling residents to 30-day discharge notice and the right to appeal.
	NH	**1999&2000** Many providers require individuals entering under the private rate to relocate when their resources are gone and most will not admit elders whose income consists of Old Age Assistance (OAA) benefits due to the disparity between their OAA income and the current cost of care in RCFs. There are increasingly fewer alternative RCFs available to individuals receiving public benefits or close to eligibility for benefits. This situation often necessitates a premature, inappropriate and significantly more costly NH placement. The situation worsened after several RCFs catering to indigent elders closed due to financial problems. **Recommendation:** Facilitate collection and analysis of data to identify the causes and impact of this issue and the ways the current structure works in conflict with public policy of choice and least restrictive and costly care environments. Collaborate with other offices to gather anecdotal and numerical data regarding the placement barriers at this level of care and the human and fiscal costs. Identify and collaborate with consumers and other stakeholders of this issue and inform and educate them and policy and law makers of the results of the above.
	OH	**1999** Continued frequency of involuntary transfer or discharge **2001** See Enforcement: Related to Regulations: Minimal/Ineffective Regulations
	UT	**2000** There are still some problems in ALFs with discharge/bed hold

Medicaid	**GA**	**1999** Some facilities fail to notify residents of their right to apply for Medicaid when their Medicare skilled nursing benefits are exhausted. Because the Medicaid reimbursement rate is lower than either the Medicare or private-pay rate, facilities have little incentive to admit or retain Medicaid-eligible residents.
	ME	**2001** RNs doing preadmission or continued stay medical eligibility assessments were only allowed to review documentation, not consider direct observations or interviews with the consumer, family members, direct care staff, the consumer's physician, often resulting in unnecessary appeals and resident anxiety. **Action:** Drafted law which was passed, to allow RNs to use professional judgement in evaluating if a consumer is medically eligibility for LTC services.
	MI	**1999** Discharge/eviction for unpaid financial reimbursement - LTC providers can choose to qualify a specific number of beds for participation in Medicare or Medicaid instead of all licensed beds. Also, the Medicaid program agency has extensive delays in processing, difficulty communicating between caseworkers and clients, even when paperwork is well prepared. **Recommendation:** Streamline the process and require facilities to qualify all beds for participation in these reimbursement choices.
	NH	**1999** See Procedures
	TN	**1999** See Procedures
Closures	**CT**	**1999** Sixty-one residents were displaced due to a NF closure. **Action:** Worked on a Relocation Plan to alleviate the trauma and protect the residents of this facility. Contracted for a study on transfer trauma.
	ID	**2000 Action:** Worked with the survey agency to monitor bankrupt facilities and meet on a regular quarterly basis to discuss this and other LTC matters.
	MA	**2000** Large number of facility closures (41 this year). Some related to bankruptcy issues, others were 'free standing' NFs that were unable to continue for a variety of reasons including inability to compete, changing populations, physical plant issues, reimbursement etc. **2001** During this reporting period 48 facilities with a total of 4,100 beds closed, most were NHs, several were board and care.
	MI	**2000** Voluntary and involuntary NH closures. LTCOP excluded from drafting of Interagency Agreement on Closures. Inadequate and inefficient enforcement of remedies before and after closures. **Action:** Discussed with local agencies the role of the agency during a closure. Developed a Closure Issue Team to submit feedback on the Interagency Agreement. Met with licensing and certification to discuss the LTCOP and state roles in closures. Trained LTCO on steps to take during and after closures and ways to prevent closures. Requested that licensing and certification give the LTCOP immediate notice of pending closures [successful]. Developed a collaborative relationship with the lead state agency during an “involuntary” closure. **Recommendation:** Licensing and certification should use the receivership law and put temporary managers and clinical managers in place as soon as a home is seriously deficient in its systems, practices and procedures. **2001 Action:** Sought connection with local community MH agencies and others to develop Closure Teams to address LTC facility closures. When unable to delay or stop these actions, provided immediate information on rights and the relocation facility to affected residents and made individual follow-up visits to relocated residents.
	MN	**2000** Ten facilities closed voluntarily for financial reasons (not bankruptcy), forcing relocation of hundreds of residents. Existing relocation rules were designed for facility closure due to enforcement action and were not adequate to address multiple closures for business reasons. **Action:** Participated in a committee convened by the state to rewrite the relocation rules clarifying facility and county responsibilities when a facility closes or downsizes requiring relocation of residents. This will be included in a bill that will create fiscal incentives for facilities to close and/or convert their business to some other type of residential LTC. **2001** The state hopes to close about 10% of the NH beds over the next two years. Legislature passed protections for residents relocated by facility closure or downsizing specifying the role of the LTCO, the county and the facility in relocation situations.

Closures (cont.)	**NH**	**2000** The closing of several RCFs, due to financial problems close to, or consisting of, bankruptcy. This may be attributable to the low rate of payment ($656.00 per month) available for services in this care environment for individuals receiving "Old Age Assistance" (OAA), which has not increased since 1988. **Recommendation:** See Assisted Living, B&C, Similar.
	NM	**2000** Due to the bankruptcies of two chains, approximately 44% of NFs are in bankruptcy. **Action:** Joined with the designated survey agency and regional managers of the two bankrupt chains in weekly conference calls. Provided guidelines to volunteers assigned to facilities in bankruptcy. Participated in several family and resident council meetings, at which facility management informed residents and families of the bankruptcy situations. **Result:** Between heightened awareness by LTCO, more frequent visits from the survey agency, and the participation of all parties in weekly teleconferences, the transition was smoothly made. We are not aware of any serious problems resulting from the bankruptcy, only problems that previously existed. **2001** One facility announced closure due to financial reasons. **Action:** Worked with residents and families throughout the discharge and appeals process, then advocated on their behalf for the state to assume receivership, and worked with a community group interested in purchasing the facility. **Result:** To avoid receivership, the facility agreed to sell to the community group. Follow-up found that residents and families were satisfied with the outcome.
	NV	**2001** The voluntary closure of four NHs this year and prior year closing of two other facilities raised issues of potential trauma to residents and of limited bed availability and consequent relocation far from families. **Action:** Participated in weekly monitoring of the discharge of residents to ensure residents and families were given choices; their property and funds were protected and that the discharge process went smoothly. Also participated in resident council meetings, discharge plan meetings, and were available to residents and their families to assist in the discharge process.
	OH	**1999** A number of facilities or NH chain corporations have reported or evidenced financial problems. The GAO states that the new payment system's aggregate payment to providers is adequate, however, the case-mix classification may not appropriately allocate payments across patients and providers. **Action:** Participated with the State Medicaid Agency and others to review the agency's resident relocation plan in the event of facility closure, loss of provider agreement, natural disaster, or other reasons. Included in the plan, distributed to LTCO, are guidelines for recognizing possible indicators of financial difficulties.
	OR	**2000** See Access to Services: Lack Alternatives or Money
	PA	**2001** Four NFs and one PCH voluntarily closed, relocating 650 residents, while facing various enforcement sanctions and financial problems. **Action:** An informal LTCOP procedure establishes communication liaisons between the enforcement agency and LTCOP at state and local levels; maintains ongoing monitoring and visibility at the facility and availability to residents and families; and after relocation, includes follow-up visits to address any problems or concerns.
	VA	**2001** A large corporately owned facility voluntary closed, resulting in abrupt relocation of residents, many to sister facilities under regulatory scrutiny for poor care, or to locations far from family, friends, and community support networks, due to lack of available beds in the immediate area on short notice. **Action:** Worked toward legislation to create additional state level protections for those LTC residents displaced when a facility voluntarily closes its doors.
	WA	**1999/2000/2001 Recommendation:** Work with RCS and HCS to develop resident sensitive procedures when an ALF is being closed.
	WV	**1999** Inappropriate discharge planning involving residents of residential B&C homes, registered unlicensed homes, etc. when these homes are forced to close. Frequently residents are hastily placed in other small unlicensed facilities and the LTCOP, advocates and state do not know where the residents ultimately go to live. **Recommendation:** Develop state policies mandating providers to report where residents are and tracking residents to insure they go to good safe homes.

Alleged Behavior Problem/ Mental Health	**MA**	**1999** Increased involuntary psychiatric hospital admissions for 'behavorial problems,' of residents who the facility identifies as 'non-compliant' or 'uncooperative with care'. Failure of the facility to adequately care plan or follow care plan that is developed.
	MD	**2000&2001** Increase in residents exhibiting difficult behaviors and experiencing drug or alcohol use and younger residents facing issues of sexuality and adapting to the LTC environment. Results include resident sexual and physical abuse, threatened discharges, and rights violations. **Action:** See Access to Services: Young Adults.
	MI	**1999** Problems with discharge/evictions for alleged resident actions/inappropriate conduct. Often facilities have not used all alternative choices to discharge (cooperative work with community MH, behavior modification techniques, speaking with family members/friends who may provide background that explains the residents actions or how to alleviate 'triggers' to behavior). **2000** Involuntary transfers/discharges by NHs alleging the physical safety of residents and facility employees is endangered. **Action:** See Procedures.
	MO	**2000** Increase in cases where the facility is attempting to discharge residents due to the behavior of family members.
	MS	**2001** LTC residents who have MH and MR diagnoses are often inappropriately placed, discharged because of problem behaviors, and transferred back and forth from the state hospital without appropriate treatment and follow-up.
	MT	**2000** Inappropriate discharges for behavioral reasons. “Dumping” of residents at hospital psych units. Facilities worried about citations from the survey agency for anyone on psychotropic medications, would rather take a discharge citation than a psych med one. See Access to Services: Dementia/Mental Illness. **2001** Facilities dump residents, lack appropriate MH services, discharge for inappropriate reasons, and lack appropriate discharge planning. **Action:** Initiated pilot teams to bring together representatives of facilities, hospitals, MH, APS, and LTCO to develop a proactive approach to care, address specialized staff training needs, and establish the LTCOP as a resource.
	NC	**1999** Individuals discharged from ACHs because they voiced complaints/asserted rights or because the staff viewed them as a nuisance. Barriers include: Licensure agency unwilling to address certain discharges as retribution for complaints under residents' rights. **Action:** See Assisted Living, B&C, Similar.
	NH	**2000** Transfer or discharge of elders presenting with challenging behaviors due to mental illness or dementia. See Access to Services: Dementia/Mental Illness
	OH	**2000** Facilities discharge residents based on the cost of providing care rather than their ability to meet the resident's needs. See Procedures. **Action:** See Procedures. **2000&2001** Hearing officers do not interpret law and rules uniformly regarding discharge. Clients who have behavioral problems are usual targets of this practice. **2001** Statutory language was changed to allow facilities to discharge residents if there is harm to any individual, including staff, so rather than doing appropriate assessment and care planning of residents with behavior problems, the facility can discharge based on health and safety. See Procedures. **Action:** See Procedures.
Non-payment	**CO**	**1999** Some involuntary transfer situations involved nonpayment due to financial exploitation by a conservator which was allowed to go on for too long (running up an unpaid bill of several months rent) before getting authorities involved. **Action:** Met with APS about their role in such cases.
	MI	**2000** Involuntary transfers/discharges by NHs alleging nonpayment. **Action:** See Procedures.
	OH	**2000&2001** Discharge is allowable for non-payment of funds, so clients are vulnerable to discharge as a result of financial exploitation by family members, guardians, and attorneys-in-fact who do not handle finances appropriately, even though the client may be powerless to change the current circumstance. **Action:** See Procedures.

No Bed Hold	**CA**	**1999** Proposed (did not become law) legislation addressed increased resident bed-hold options.
	MI	**2001** Refusals by NHs to readmit residents who had been hospitalized.
	NH	**1999** Residents transferred under emergency circumstances are not provided with written notice of the transfer, bed-hold options and the right to re-admission to the next available bed (if the option of making payment to hold the resident's bed is not exercised), prior to or soon following the transfer and thus are not getting to exercise their readmission rights. If the facility believes they have acceptable grounds for discharging the individual, they rarely provide the required written 30-day notice of involuntary discharge, specifying the reasons for discharge and including the statements about resident appeal rights. **Recommendation:** See Procedures.
	UT	**2000** There are still some problems in ALFs with discharge/bed hold.
Level of Care Related	**CO**	**2001** Lack of proper assessment and care planning. Residents are admitted to facilities that are unable to meet their needs. Residents are not fully informed as to their rights related to discharge/eviction - planning, notice, and procedure
	CT	**1999** The state licenses two levels of NF care. Residents are transferred when they require the higher level of care. **Action:** Intervene and get most transfers reversed.
	HI	**1999** Facility replaced SNF with short-term rehab Medicare unit and wanted to discharge all residents in SNF and replace them with maximum one or two week stays. **Action:** Addressed this concern with health department. If facility is certified for Medicare, it should have to provide full 100 days if medically needed by resident. Facility agreed to let residents stay if they refused to move, but most did agree to be discharged elsewhere.
	ME	**2001 Action:** Helped negotiate a rule stating that consumers experiencing three moves and two findings of Medicaid NF ineligibility in a nine month period are eligible to remain in the NF under the 'Frequent Changes in Care Setting' exception. This aids consumers moving in and out of a NF because of chronic medical conditions.
	RI	**2001** There are over 230 NH residents on state waivers who have improved and no longer need nursing care. **Action:** Already assisted 75-100 NH residents to return home after helping set up some community intervention support services or to move to ALFs of their choosing.
	WV	**2000** NHs and hospitals seem to be dumping residents on each other.
Procedures	**AZ**	**2001** The priority issue was inappropriate discharge. Most discharge issues were resolved by talking with the facility to assure proper and safe discharge.
	CO	**1999** Increased involuntary transfer complaints often due to inadequate notice or facilities not following regulations regarding permissible grounds for involuntary discharge. **Action:** Provided extensive training on transfer/discharge rights to local LTCO and facilities. **Result:** Reduced involuntary transfer/discharge complaints. **2001** See Level of Care Related.
	MI	**2000** The NF resident being involuntarily transferred/discharged often does not challenge the action or is unrepresented and unable to defend himself during hearings. The LTCOP is not given copies of transfer/discharge notices nor all hearing decisions. **Action:** Developed a team to gather and develop resource materials for use by LTCO. Invited the chief justice to speak about the law's requirements, the hearing procedures and how best to help/advocate for the resident. Requested assistance from legal services programs in hearings and in solving problems leading to involuntary transfers/discharges. Parties agreed to develop joint training for/by LTCO, legal services attorneys, private attorneys and the Bureau of Hearings and to explore ways to prevent involuntary transfers/discharges and to track hearing results. **2001 Action:** Produced and distributed an instructional manual to assist statewide with this issue.

Procedures (cont.)	**MT**	**2001** See Alleged Behavior Problem/Mental Health.
	NC	**1999** See Transfer and Discharge: Assisted Living, B&C, Similar.
	NH	**1999** State regulations only provide an administrative hearing right to Medicaid recipients and even that is not available for involuntary transfers or discharges caused by an emergency. See No Bed Hold. **Recommendation:** Change state policy and procedures to ensure residents are properly notified and provided with support to exercise their right to an administrative hearing to challenge involuntary transfer/discharge. Collaborate with state agencies and provider groups to ensure knowledge, understanding and compliance with the above. Educate residents and family members about federal transfer and discharge protections.
	OH	**2000** The client has the statutory right to a hearing by the regulatory agency, however, the decision is not binding and the facility may still discharge the client. Families are not given appropriate notice and are instead told that a different facility is better equipped to provide care. There is no appeal process if the hearing decision goes against the client. **Action:** Offered training to regional programs to assist clients in use of additional options and strategies in preparation for hearings. Have injunctive authority when a resident's rights are violated and obtained a temporary restraining order against a facility which attempted to discharge a resident for obviously inappropriate reasons. Did legislative review of current statute. **2001** The administrative hearing is now binding; however, when the hearing is not in the client's favor, the next level of appeal is court, which is beyond the means of most residents. See Enforcement: Related to Regulations: Minimal/Ineffective Regulations. **Action:** Offered training to case handler to assist clients in use of additional options and strategies in preparation for hearings. Have injunctive authority for use when a resident's rights are violated. Got some concessions during legislative review of new statute. Revised reporting to track success rates in discharge hearing representation.
	TN	**1999** A family member was told that due to a denied PAE, her mother would have to be transferred/discharged, but she had not received any written notice of denial from the medical review unit. The facility had phoned the medical review unit and was told that the resident would not be approved. Without waiting for a written notice of denial, the facility proceeded to inform the resident's family member. Without the written letter of denial, residents and family members have no way of knowing who to contact in the event that they wish to appeal. Nor are they given any reasons for the denial.
	VT	**2001** State NH regulations referenced a resident's right to appeal, but did not describe the process. There was a perception that most discharges or transfers were justified or voluntary, so there was no need for an appeal process. **Action:** Advocated for and got a formal appeals process added to the regulations which also inform residents of their rights and responsibilities when faced with a notice of transfer or discharge.
Admissions		
Selection	**TN**	**2000** Relatives don't know how to select the preferred future home of a loved one and assure their safety. **Action:** Encouraged them to visit the facility or facilities of choice prior to a final selection; provided latest issue of HCFA's "Guide to Choosing a Nursing Home;" encouraged frequent visits with their loved ones.
Medicaid	**GA**	**1999** Medicaid-eligible applicants have more difficulty gaining admission to NHs than do private pay or Medicare applicants.
	KS	**1999/2000/2001** See Access to Services: Lack Alternatives or Money.
	MD	**2000&2001** Increasing need by residents of LTC facilities and family members for legal assistance. Identified issues include Medicaid discrimination.
	ME	**2001** See Discharge or Transfer: Medicaid.

Medicaid (cont.)	**VT**	**2000** The state requires NHs to follow the same admission practices for all individuals regardless of source of payment, yet many Medicaid recipients have a difficult time finding NH placements. **Recommendation:** The state should explore ways to enforce the existing state anti-discrimination provision and the federal government should adopt a similar provision that could be enforced through the federal survey process.
Lack Money	**NH**	**2000** Most residential care/ALFs will not admit elders whose income consists of Old Age Assistance benefits. **Recommendation:** See Transfer and Discharge: Assisted Living, B&C, Similar.
	NV	**1999** Access to affordable ALFs is more of a problem with many high-end facilities run by national corporations and scarcity of smaller 'mom and pop' facilities.
Limited/ No Licensed Facilities	**DC**	**2000** Due to the shortage of safe housing, CRF (Community Residence Facility) residents are often placed in unlicensed facilities where insufficient attention is paid by MH services to the physical conditions of the facility. There is a lack of coordination between MH and the health department, which is reluctant to impose fines or penalties or close down unsafe homes for violations of housing codes, licensing regulations and residents' rights. **Recommendation:** Civil infractions for CRFs that impose higher monetary penalties. Register the severity of the issues and generate a supply of quality, CRFs and assisted living residences.
	MD	**2000** There are limited licensed facilities - many facilities have licensure pending, some smaller ones closed, and others have not applied for licensure. Issues include lack of supervision, resident care, financial exploitation by providers, safety issues, and contract/service concerns. The cost of staff training and meeting other licensor requirements is prohibitive. The process for licensing these facilities and the work needed to maintain facility compliance remains backlogged and overtaxed. **2001** There is a backlog of facilities awaiting licensure but operating with a pending status.
Limited due to Low Staff	**MN**	**1999&2000** Some facilities placed voluntary bans on new admissions and closed down beds due to staffing shortages. **2000 Action, Recommendation, and Result:** See Staffing: Job Related: Insufficient Staff.
Level of Care	**CO**	**2000** Residents needing a higher level of care are admitted to PCHs, putting them at risk for abuse and neglect. The owners are reluctant to discharge as they need the income. There is stiff competition due to overbuilding. Families tend to put pressure on the owner/operators because they do not want their family member in a NF. Regulations governing PCHs are very weak. **2001** Lack of proper assessment and care planning. Residents are admitted to facilities unable to meet their needs. See Discharge or Transfer: Level of Care Related.
	KY	**2000 Action:** Working to assist in the implementation of Olmstead requirements. (Least restrictive level of care.)
	MO	**2000** Presumably due to low occupancy, facilities accept residents with care needs or problems beyond staff capabilities.
	UT	**2001** New ALFs continue to be built, despite the low census in NHs and ALFs. Due to the competition, ALFs tend to keep residents too long.
Contract Issues	**HI**	**1999** Several care homes have been charging residents for transportation for doctor's visits, basic toiletries like tooth paste, soap and shampoo, toilet paper, laundry, etc. **Recommendation:** above items should be clearly stated in writing in the contracts as part of room and board rate.
	MD	**2000&2001** Increasing need by residents and family members for legal assistance. Identified issues include contract/service concerns.
	ME	**1999 Action:** Participated in a work group with health department and providers to develop a model NH contract, which was enacted requiring facility use. **2000** Development of standardized contracts for RCFs - **Recommendation:** Develop and adopt rules to require the use of standardized contracts to be used in RCFs. **2001 Action:** Helped get law passed requiring state to promulgate rules for a standardized contract that must be used by ALFs.

Contract Issues (cont.)	**UT**	**2000** There are still some problems in ALFs with contracts.
	WA	**1999&2000 Action:** LTCO legal counsel is working with provider associations and state on a standard admission contract for assisted living. **2000 Action:** With the industry, sponsored training for consumers on legal admission agreements and for providers on the limitations of admission policies.

Access to Services

Medicaid	**CO**	**2000** See Special Needs.
	MI	**2001** Difficulty in becoming Medicaid eligible.
	MT	**2000** Lack of Medicaid reimbursement for MH issues in LTC facilities. **Recommendation:** Change Medicaid reimbursement structure.
	WA	**1999/2000/2001 Action:** Joined with other advocates and provider associations to seek adequately funded LTC services for Medicaid recipients. **2000 Action:** In coalition, developed legislation to make financial eligibility for Medicaid Waiver residential programs equal to NH financial eligibility. **2001** The state Medicaid Waiver allows expenditure of 90% of the average NH daily rate for residential or home care; however, the state severely limits payments, for example paying 55% in urban, high cost areas. This results in neglectful care for residents or forces them into early NH placement.
Young Adults	**MA**	**2000** Increasing numbers of younger mentally ill residents on the same unit as elder residents, with need for different approaches in activities, staff interactions. **2001** Increase in younger brain injured, behavioral and or MH residents. One national chain contracted with a neighboring state to provide 'behavioral services' through the 'criminal diversion program', resulting in a significant problem with resident to resident physical and sexual abuse issues.
	MD	**1999/2000/2001** Increase in residents exhibiting difficult behaviors and experiencing drug or alcohol use and younger residents facing issues of sexuality and adapting to the LTC environment. Results include resident sexual and physical abuse. Few facilities can accommodate their needs. **Action:** Continue to provide case consultations, conduct in-service training sessions for residents and staff, and seek other solutions. **1999** With decreased occupancy rates, issue spread statewide. Prostitution and illegal drug and alcohol possession required law enforcement intervention. **Action:** Convened Task Force to identify extent of problem, develop model policies, and coordinate facility staff, law enforcement officials, regulatory agency, and advocates. **2000&2001** Results include threatened discharges and rights violations. **Action:** Work with state to identify younger residents suitable for community placement through the waiver programs and work with appropriate entities on expanding treatment programs for NFs. **2001 Action:** Plan LTCOP training with the MH network on how to identify and respond to these issues. Provided mediation training to LTCO on additional strategies.
	WY	**1999&2001** Placement of younger seniors (50-65) and adults (21-50) in LTC facilities, and the facility's ability to accommodate psycho/social needs. Many younger residents express needs for social activities outside of the facility, for a younger roommate, for flexible visiting hours, for access to a computer/internet, etc.
Lack Alternatives or Money	**CA**	**2001** The Olmstead Decision requires a community-based system of care. **Recommendation:** Education, training, and incentive programs for community-based services and families. State has a grant project to pilot transition services and community based care.
	GA	**1999/2000/2001** Current LTC services are insufficient or unaffordable for individuals needing some assistance, but not requiring NH care. **Recommendation:** Develop additional LTC residential options, including adding limited nursing services in qualified PCHs (i.e., assisted living levels of care) with appropriate protections for residents. Continue to allocate resources to community-based LTC services to meet the needs of persons who are older or who have a disability. Develop a consumer-centered system to help consumers and caregivers access appropriate services for their needs.

Lack Alternatives or Money (cont.)	**ID**	**2001** Olmstead planning group recommendations to the health department for further consumer input not acted on and no individuals have been assisted.
	KS	**1999/2000/2001** Individuals fail to save, insure, or otherwise lack resources necessary to pay for NH care and must deplete their assets and rely on Medicaid to pay for care. In response to increasing public costs, state and federal governments have attempted to restrain the number of available beds and payment rates to those NHs, which led to an increasing cost-shift to private-pay residents. **Recommendation:** Encourage people to plan ahead or insure for future LTC expenses.
	KY	**2001 Action:** Worked on public forums to inform state of need for programs to assist NH residents in getting care in their home community.
	MD	**1999** Many smaller homelike facilities are unable to meet new licensing requirements, raising concerns about their ability to provide affordable housing alternatives.
	ME	**1999** Waiting lists for the state-funded Home Based Care Act program place consumers at risk, since they only qualify when they are not eligible financially and medically for other funding programs. **Action:** Submitted legislation, which was carried over, to eliminate waiting lists and create an entitlement to these services.
	MN	**2001 Action:** Participated in a state government task force to refocus from a LTC system of institutional care to one offering more home and community based service options. Legislature passed to identify gaps and develop new resources on a county by county basis for those needing LTC services.
	NH	**1999&2000** See Transfer and Discharge: Assisted Living, B&C, Similar. **2001** Significant barriers to access to assisted living/residential level of care by poor and near poor elders forces some elders into NH care.
	OR	**2000** As more facilities close due to financial problems, some in rural areas may close, forcing residents to leave their communities and their families. Low facility occupancy, residents with complex care needs, inadequate staffing and relatively low reimbursement are all cited as contributing factors. Declining state revenues resulted in proposals to cut current LTC services. The licensing agency has been working with NF representatives in an effort to increase occupancy by finding ways to reduce unneeded NF capacity. **Recommendation:** Long-range strategic planning as reflected in bills before the legislature.
	VA	**2001 Action:** Offered sessions on Olmstead Decision interpretation and implementation plans, with strategic plan presentations by policy makers and agency directors.
	WA	**2000** Olmstead-oriented advocacy is often related to moving individuals from NHs and state facilities to large boarding homes/ALFs, which are no more community oriented. **Recommendation:** Shift toward community integration rather than license type as the determinant of Olmstead advocacy. **1999&2000 Action:** Chaired a task force to review the LTC service system and recommend improvements. Issues included poor wages for providers, inadequate choices for in-home and residential care, resident rights protection, and the balance between safety and consumer choice/preference. **2001** See Medicaid.
	WV	**1999** There are not enough PCHs, residential B&C homes, or smaller varieties of LTC homes available to middle and low income residents. **Recommendation:** The government needs to supplement the amount of money that these people can afford to pay for their care. **2001** ALFs say they cannot afford to care for low income residents and prefer middle and upper income level residents who can pay higher rates. **Recommendation:** Raise state supplement paid to ALFs for low income residents to a level comparable to what middle income residents pay.
Special Needs	**CO**	**2000** Residents lack appropriate wheelchair seating as a result of poor physical therapy and wheelchair assessments, reimbursement time delays, facilities unwillingness to buy the equipment needed, residents and families not knowing their rights, and the fiscal impact on the state of Medicaid reimbursement for customized, electric wheelchairs costing $12,000 or more. **Recommendation:** Change Medicaid so customized wheelchairs are directly billed through a prior authorization process to speed reimbursement and motivate facilities to act promptly when residents need equipment. Make legal assistance available for denial appeals. Train providers, facility staff, surveyors and LTCO on the importance of appropriate durable medical equipment and on how to assess for proper positioning.

Special Needs (cont.)	**CT**	**2000** Non-medical transportation. **Action:** Commissioned a study on how lack of access to transportation by NH residents affects the quality of their lives.
	KY	**2000 Action:** Working with hearing impaired to secure appropriate care for deaf and to be sure ADA is complied with.
	OH	**2000** The Residential State Supplement Program was intended for older adults requiring a protective level of care, less than NH, more than ALF, who also qualify for Medicaid under a special income waiver. Instead, program openings have been filled with younger individuals from the MH system with special needs that were not fulfilled within the current system. There is a lack of communication and the responsibilities between multiple case management entities cause conflicts between consumer issues and agency issues. **Action:** Served on ad hoc and rule review committees to ensure the rights of consumers were protected. Will serve on an oversight committee formed to monitor the implementation of the revised rules. Have been requested to participate in foundation training of providers regarding resident rights.
Dementia/ Mental Illness	**GA**	**1999** Current LTC services are insufficient or unaffordable, particularly for individuals with dementia needing constant supervision but not intensive nursing services. **Recommendation:** See Lack Alternatives or Money **2000&2001** Individuals with severe mental illness often reside in NHs, due to state psychiatric facilities down-sizing and insufficient MH system resources. Some individuals' needs could be met in the NH setting, while others need more appropriate placements. Despite the PASARR (Preadmission Screening and Annual Resident Review) system for NH residents, critical needs of residents with mental illness are not met. **Recommendation:** Coordinate the PASARR system and MH Services agencies. Ensure NFs provide adequate assessment of residents MH needs and appropriate treatment. **2000 Recommendation:** Evaluation of the PASARR system.
	MA	**2000** Increasing numbers of younger mentally ill residents on the same unit as elder residents, with need for different approaches in activities, staff interactions. **2001** Increase of younger brain injured, behavioral and or MH residents. One national chain contracted with a neighboring state to provide 'behavioral services' through the 'criminal diversion program', resulting in a significant problem with resident-to-resident physical and sexual abuse issues.
	MI	**2000** NH personnel lack: understanding and training in proper assessment of persons exhibiting threatening or difficult behaviors due to mental illness, dementia, or other disability; training and staffing to implement proper interventions; and access to and knowledge about use of available MH and substance abuse programs and treatments. **Recommendation:** Good, reliable community treatment services, interventions and/or programs for poor persons in NHs.
	MN	**2001 Action:** Collaborated on passed legislation requiring housing providers which market special services for people with dementia to provide written disclosure to the consumer and the LTCO office, including the credentials of staff, criteria for admission and discharge to the special care units, information on special programs for residents and a description of the physical environment adaptations for people with dementia.
	MS	**2001** LTC residents who have MH and MR diagnoses are often inappropriately placed, and discharged because of problem behaviors, and transferred back and forth from the state hospital without appropriate treatment and follow-up.
	MT	**2000** Lack requirements regarding MH issues in LTC facilities. Lack Medicaid reimbursement. LTC staff untrained and unequipped to work with residents with MH issues and/or challenging behaviors. **Recommendation:** Change Medicaid reimbursement structure. Add federal regulations on appropriate MH treatment. Specialized training curriculum and requirements. Work with facilities, certification and the medical community to establish appropriate guidelines for meeting residents' needs. Assist facilities through increased training opportunities, consultations, to think "outside the box", and establish a working relationship with the MH system.
	NC	**2001** MH consumers need advocacy.

Dementia/ Mental Illness (cont.)	**NH**	**1999** Very limited placements are available to individuals whose behaviors pose a danger to others and cannot be properly cared for in the traditional NH. Limited human resources available to provide education and training in the nature of dementia and appropriate means, modes and methods. Funding prohibitions within the MH system limit employment of professionals possessing expertise in behavior management. Most LTC facilities were not constructed and many cannot be altered to accommodate the environmental needs of individuals with dementia. **Recommendation:** Review with agencies and individuals demonstrating expertise, the issues concerning service and care provided to persons exhibiting challenging behaviors. With Alzheimer's specialists, develop and present a state-wide 'train the trainers' education program for nurse managers and directors which would certify and require participants to provide similar programs for sister and neighboring facilities. **2000&2001** Limited beds are available for elders with challenging behaviors due to mental illness or dementia. The physical environment, staffing patterns and care-giver training are inadequate, unsuitable, and often behaviorally provocative. Limited financial resources are available to compensate for the high acuity level and related high costs of care, or for expansion of atypical behavioral unit systems. **2000 Recommendation:** Survey LTC and MH providers and counselors to determine the scope and severity of the problem. Intervene and advocate, on a case-by-case basis, when placements cannot be found or facilities seek to transfer or discharge residents with extreme challenging behaviors and collaborate and explore options to accommodate their special needs. Participate in, and/or monitor activities of state agencies regarding atypical utilization usage and the potential for “main streaming”. Advocate for elders currently residing in the state's atypical units to assure their needs continue to be met in an appropriate manner.
	OH	**2000** The MH population has special needs that were not being fulfilled within the current system. There is a lack of communication and the responsibilities between multiple case management entities cause conflicts between consumer issues and agency issues. **Action:** See Special Needs.
	RI	**2001 Action:** Assisted in placing state hospital patients into appropriate NHs that can meet their needs, when the severe behavior conditions that caused them to be hospitalized were no longer a deciding factor and they had medically declined or were very aged.
General Issue: Enforcement		
Related to Regulations		
Assisted Living, B&C, Similar	**AL**	**2000**. There were no regulations for ALFs housing dementia residents and some residents were eloping and getting injured or dying. A state convened work group developed a level of Assisted Living for dementia residents called specialty care facilities, which requires a Certificate of Need to be licensed. **2001** Law passed to set up a licensure program for administrators of ALF's.
	CO	**2000** The regulations governing PCHs are very weak.
	DC	**1999 Recommendation:** Combine the B&C system with an effective monitoring and enforcement system for licensed ALFs. Require facilities to provide a homelike atmosphere that accommodates residents' changing care needs, preferences, personal dignity, autonomy, independence, and privacy.
	HI	**1999** New administrative rules state facilities cannot advertise as 'Assisted Living' unless licensed, but no facilities have applied for a license. **Action:** Contacted department of health asking them to enforce the law and to insist ALFs comply with the law, undergo annual inspection and provide access to LTCOP.
	ID	**2000** After a state waiver and changed regulations allowed more seriously ill elderly to reside in ALFs, quality of care related complaints increased.
	IL	**1999/2000/2001 Action:** Continued participation in the development of law and rules to define and create ALFs in state. Concerns included residents' rights, involuntary discharge protections, general oversight with enforcement and LTCOP access and services for residents. New rules effective Dec 1, 2001.

Assisted Living, B&C, Similar (cont.)	**MD**	**2001** The system for licensing ALFs and bringing them into compliance remains backlogged and overtaxed.
	MI	**2000** Hundreds of ALFs are unlicensed and unregulated. The state has limited the LTCOP to complaint resolution in licensed facilities (NHs, county medical care facilities, hospital LTC units, and licensed ALFs.) **Action:** Got the state to enforce ALF licensure laws in unlicensed ALFs which provide or arrange for care requiring licensure. Advocated against failed legislation to permit unlicensed ALFs to govern their relationship with residents via contracts, rather than licensure and regulation.
	MT	**2000** Existing rules are very minimal and allow for inappropriate services to exist. Expanded rules are currently being developed to address this issue.
	NM	**2001** A bill requiring RCF operators to meet additional minimum standards was passed but vetoed by the governor
	OH	**1999** There is limited regulation, despite the dramatic increase in facilities. The regulations regarding medication administration are an accident waiting to happen. **2001** See Minimal/Ineffective Regulations
	OR	**1999** See Survey Related: Role of Regulators (help vs. oversight)
	PR	**2000** Continued problems with outdated law and regs concerning B&C facilities and with an uncooperative licensing agency. **2001** Continue to push for improvement in licensing and supervision of B&C facilities.
	RI	**2000** There are few regulations for ALFs or RCFs, which leaves administrators and owners at liberty to financially exploit the residents and provide inappropriate levels of care. Residents fall through the cracks until their safety and health require emergency attention.
	UT	**1999** The past laws governing these facilities have been very vague. New rules are being drawn up with special attention on medication administration and criteria for keeping/accepting residents. These facilities take more acute residents than in the past without an increase in staff numbers or expertise. Facilities are now using 'secured' units that seem to be nice places to put unwilling elderly family members until they get the court to deem them 'incompetent'.
	WA	**1999&2000** The legislature authorized a study of Third Party Accreditation for ALFs. A task force of advocates and providers is seeking a way to merge accreditation with licensing; perhaps by allowing fewer inspections for accredited facilities. The task force reviewed CARF and JACHO assisted living standards and discussed many possible configurations. The LTCOP and AARP Chapter have remained skeptical that accreditation could or should have any tie to licensing. **2000&2001 Action:** Participate on committee with advocates and providers to establish appropriate regulations for boarding homes.
	WV	**2001** Lack of oversight for registered unlicensed homes (those with three or less residents). State regulations prohibit the survey agency from entering these homes except for complaint investigation. **Recommendation:** Hire another LTCO to work with small ALFs including registered unlicensed homes. Change state regulations and mandate that the survey agency enter these homes on a routine basis for monitoring purposes in addition to investigating complaints.
Minimal/ Ineffective Regulations	**DC**	**2000** Proposed NH regulations were published for comments three times by the health department without strengthening standards and protections for or providing an enforcement system. Each publication has not rendered them stronger than federal regulations, resulting in confusion in the LTC community regarding their efficacy. **Recommendation:** The health department should create a coalition to research and analyze the best practices and strategies used by other states.
	HI	**1999** Most facilities, those under 120 beds, are not required by federal law to hire licensed social workers, resulting in increased hiring of social service designees without training or understanding of strong advocacy for residents. **Action:** Worked with university gerontology program to improve the curriculum, encourage social work students to enter gerontology and provided mini-workshops for those working as social workers in NHs without an academic background in social work.

Minimal/ Ineffective Regulations (cont.)	**MS**	**2000** Continued staffing shortage and inadequate staff training in NHs. Regulations were adopted to increase staffing ratios - 2.67 hours to 2.80 hours of direct nursing care per resident per day. **Recommendation:** Increase enforcement to promote adequate staffing. Replace current Personnel Hours System (which allows a facility to use those hours during the morning and/or afternoon shifts, neglecting the needs of residents during the night shift) with direct care staff-to-resident ratio regulations. **Action:** Monitor facilities and advocate for regulation changes to increase staffing ratios as needed.
	MT	**2000** See Access to Facilities and Services: Access to Services: Dementia/Mental Illness.
	NC	**2001** New ACH transfer/discharge rights rule does not reflect intent of law, which was to be as protective as NH transfer/discharge rule. Work group developing new rules related to quality care for ACH residents has insufficient consumer/LTCO representatives and has heavy provider representation.
	OH	**2000** Lack of ACF accountability under regulations. For example, the regulatory agency writes the plan of correction for each ACF citation. **Action:** Served on rules committees. Will serve on oversight committee monitoring the revised rules implementation and will participate in training providers regarding resident rights. **2001** The health department's interpretations of newly revised NH and RCF rules were broad and less resident focused than intended, making advocacy efforts potentially more difficult regarding transfers and discharges, staffing, and RCF admissions. New complicated and difficult to calculate NF staffing rules require 2.75 hours of service to the average resident per day. **Action:** LTCO was essential member of committees and workgroups that reviewed and commented on the revisions.
	VT	**2001** New regulations require a minimum 3.0 hours of direct care staff per resident per day averaged over a week. Residents or family members have difficulty determining if the facility meets this standard and there is concern that a facility can be significantly understaffed at times and still meet the minimum standard.
MI/MH Related	**IL**	**2001** Lack specific state regulations for Alzheimer's units and facilities having residents with mental illness. **Action:** Involved in planning annual MH and aging conference and ongoing development of Alzheimer's unit laws/rules and of rules for MH institutes and NHs with serious MH problems in less than half the residents.
Changing Regulations	**OH**	**1999** State enforcement regulations did not meet new federal regulations. **Action:** Provided input used in drafting legislation believed to meet federal requirements. **2001** See Minimal/Ineffective Regulations.
Survey-Related		
Lenient/ Inadequate Enforce-ment	**DC**	**1999** Lenient enforcement of NFs and B&C homes. **Action:** Submit recommendations on proposed NH rules, emphasizing a strong, swift process that fully employs new federal initiatives; organize resident and family groups to comment on the rules regarding how lack of enforcement adversely affects care. **2000** Insufficient oversight and enforcement of CRFs, especially for mentally ill. See Access to Facilities and Services: Admissions: Limited/No Licenced Facilities
	MD	**2001** It has been difficult to provide the needed oversight of ALFs to ensure compliance with existing regulations and respond in a timely manner to complaints.
	MI	**2000** See Access to Facilities and Services: Transfer and Discharge: Closures.
	MS	**2000** PCH inspections are rare to nonexistent due to limited funding and regulatory staff. Regulations are not enforced, licenses expire, and new homes open for business without a license. **Result:** Additional funding and advocacy efforts increased staff.
	OH	**2001** See Related to Regulations: Minimal/Ineffective Regulations.
	UT	**2000** Enforcement seemed to be getting better, but now seems to be lagging again.

Fragmented Responsi-bilities	**GA**	**1999** Enforcement will be weakened if PCHs contracted with MH/MR/Substance Abuse services are no longer monitored by the regulatory office. **2001** New standards proposed by MH/MR/SA for PCHs within that system. These PCHs should be required to meet at minimum the same standards as other PCHs.
	ID	**2001** Medicaid waiver program allows NH-type beds in ALF (>5 beds) or Certified Family Homes (<5 beds). Increasing enrollment, inconsistencies in administration, and minimal certification and monitoring systems raise quality of care and oversight concerns. **Action:** Serving on a task force designed to develop effective oversight.
	MD	**2000&2001** Abuse continues in ALFs in part due to lack of clearly defined responsibilities for identified agencies and limited oversight of many facilities.
	ME	**2001** Insufficient monitoring of home care cases by the two agencies charged with coordinating delivery of care resulted in problems with quality of care and missed identification of need for services at a higher level of care. **Action:** LTCOP drafted law passed to have agencies better coordinate the delivery of home care services.
	WA	**1999&2000 Action:** Supported and participated in transfer of boarding home jurisdiction to DSHS, the agency overseeing NFs.
Role of Regulators (help vs. oversight)	**OR**	**1999** Three RCFs operated unlicensed for years. When identified, if the RCF is amenable to licensing, the licensing agency works with it to bring it into minimal compliance and does not invoke sanctions, so there is no disincentive for operating unlicensed. One facility was primarily interested in licensing so residents could use their LTC insurance benefits. **Recommendation:** Develop rules clearly defining when a facility must be licensed and sanction facilities violating the law.
Measure Outcome vs Cause	**NH**	**1999** Surveyors cannot substantiate inadequate staffing unless they can show negative resident outcomes which can be clearly linked to inadequate staffing. This is difficult to accomplish and necessitates measurable poor care, harm or injury to vulnerable elders before the cause can be identified. **Recommendation:** Change the survey process to identify unacceptable 'risk factors' to poor care or potential harm to residents based upon number of vacant direct care positions, turnover rate, percent of agency staff employed etc. Require quarterly reporting of the indicators to the state agency. Develop a central data system to identify statewide trends.
	OH	**2000** Federal surveys are designed to measure outcomes rather than process. Staff ratios remain a process standard and are thus not a dominant part of the standard survey. Based on their own statistics, the survey agency reports an increase in bowel incontinence, bladder incontinence and pressure sores, which are often cited under care and services rather than staffing. **Action:** Participating in review and revision of the licensure rules (required every 5 years) which includes an increase in the staffing ratio. Conducted letter writing campaigns, made media contacts, and contacted legislators to support staffing ratios in the rules and in state legislation. **2001** Federal surveys often cite outcomes of bowel and bladder incontinence and bedsores in care and services rather than as a result of staff shortage. The rule revisions are complicated and difficult to calculate as they are based on 2.75 hours of service to the average resident per day.
Insufficient Survey Staff	**CA**	**2000** A law was passed and signed which adds funding for approximately 100 new Licensing and Certification evaluators.
	ID	**2001** See Fragmented Responsibilities.
	MS	**2000** See Lenient/Inadequate Enforcement.
	UT	**1999** The health department has nursing staff problems and so has been behind in regular surveys and been unable to do complaints investigations within 10 days.
	WA	**1999** Oversight of boarding homes, Assisted Living issues - **Recommendation:** Adequate survey agency resources to oversee boarding homes.

Ineffective Sanctions	**CA**	**1999** Proposed (did not become law) legislation addressed increased civil penalties. **2000** A new law increases fines for serious NH regulation violations from $25,000 to $100,000, expands reviews of poor performing NHs, and provides for a temporary manager in cases of severe fiscal mismanagement of facilities.
	MD	**2000** Law passed establishing the authority to impose civil penalties of up to $10,000 and to take other actions against facilities with serious compliance problems.
	ME	**1999** State Fines - **Action:** Submitted legislation which was enacted to increase state fines for NFs that violate NF regulations.
	NM	**1999** Residents experience horrendous neglect. The facility may have sanctions levied, but care doesn't improve, since it costs less to pay (or fight) sanctions than to provide good care. **Action:** Cooperating in a task force to increase legal referral of abuse, neglect and exploitation cases when desired by residents or their families.
	OR	**1999** A corporation with almost 20 percent of the state's ALFs, was assessed over 67% of the total civil penalties and received two of three admission restrictions levied by the state. Efforts by regulators and LTCO to address care problems were met by administrators claiming insufficient corporate support, which was denied by corporate personnel. The corporation clearly focused more on expansion than day to day operations. See Role of Regulators (help vs oversight) **Action:** Issued a press release in each community having a sanctioned facility. **Result:** Articles got corporate attention and fewer facilities were assessed sanctions in the next year.
	PA	**2001** Four NFs and one PCH voluntarily closed, relocating 650 residents, while facing various enforcement sanctions and financial problems.
	WA	**2001 Action:** Successfully staved off boarding home industry efforts for legislation to significantly reduce care-related penalties and to prohibit sanctions until three residents were harmed and then only if the cause is systemic.
Survey Procedures	**AL**	**2001** Law passed to allow the health dept. to go into unlicensed ALFs.
	CA	**2000** New law increases unannounced inspections, expands reviews of poor performing NHs, and provides for a temporary manager in a severely mismanaged facility.
	HI	**1999** By administrative rule, the health department as licensing agent is required to provide 'approximate time' of annual inspections for adult residential care homes. **Action:** Strongly opposed and health department agreed and insisted on unannounced visits in new rules. Participated on committee to re-write rules.
	MD	**2000** Legislation passed increasing to two the number of full surveys, with the option to waive the second survey for facilities with no compliance problems.
	MI	**1999 Action:** Encouraged the state licensing department to visit facilities in the evening, holidays, and on week-ends when most short staffing occurs.
	NM	**1999** Too often residents' complaints of poor quality care are ignored in favor of staff written comments. **Action:** Conducted four Anonymous Care Evaluations, which placed a LTCO or contracted individual as a resident in each of four facilities, to sample the care provided.
Deficiency Dispute Procedures	**MN**	**1999** The health department must now revise its process for informal dispute resolution on facility deficiencies. Previously, there was only a written process for facilities to challenge a citation; now they must be offered an opportunity for a face to face discussion of disputed deficiencies.
Complaint Investiga-tion	**CA**	**1999** Proposed (did not become law) legislation addressed complaint management.
	GA	**2000 Action:** Completed a study which identified serious problems in the regulatory complaint investigation process. **Recommendation:** Improve the timeliness and thoroughness of investigations. Allow dissatisfied complainants to seek a review of an investigation. Adequately fund the agency to meet these goals.

Ownership/ Accountability Issues

MA	**2000** See Access to Facilities: Transfer and Discharge: Closures.
NM	**2000&2001** See Enforcement: Ownership/Accountability Issues.
NV	**1999** Rapid growth in skilled NFs and residential facilities for groups. Changes in ownership and new administration create continuity problems. Access to affordable assisted living is more of a problem with many high-end facilities run by national corporations and scarcity of smaller 'mom and pop' facilities.
OH	**1999 Action:** Established workgroup to address repeat complaints in chain facilities and alert other LTCO about identified concerns or provider financial problems. Identify, track and share information on individual facilities and chains via a Wide Area Network. The workgroup tracks complaints and successful resolution strategies to assist clients experiencing problems and to provide data to federal agencies and legislators to amend public policy as necessary.
OR	**1999** See Ineffective Sanctions.
PA	**2001** Four NFs and one PCH voluntarily closed, relocating 650 residents, while facing various enforcement sanctions and financial problems.
TX	**2000** At the end of the fiscal year, 24% of the state's NFs were in bankruptcy, creating major concern for providing quality care to the residents.
UT	**1999** Many changes in ownership and more movement in administrators and other staff than in the past.

Fraud: Medicaid and Medicare

GA	**1999** A few providers are billing for services not provided, billing services at a higher rate than allowed, and following other fraudulent or abusive practices. **Action:** Educating seniors and people who serve them to recognize signs of fraud and abuse so they can report suspected problems and prevent fraud from occurring.
MI	**1999** Inappropriate billing/questionable charges- barriers include complex and confusing public/private payment systems, incentives to bill fraudently. **Recommendation:** Move to a single payor health system and increase government resources to monitor accounting and prosecute fraudulent providers.
MS	**2000** Some providers file false claims and bill for services that are not provided, not necessary, or at a higher rate than allowed. **Action:** Support a training program to educate seniors and people who serve them to recognize signs of fraud and abuse so they can identify and report suspected problems.
NY	**2000** Health care fraud and abuse deprives seniors in facilities and in the community of essential health care dollars. **Action:** Expand the outreach and training program to reach caregiver families, seniors, and the general public; including non-English speaking Medicare and Medicaid eligible seniors. Hold a national teleconference to share proven best practices in outreach, training, and coalition-building. Maintain a national resource library for all state units on aging.
PA	**1999&2000 Action:** Produced a standardized training course, manual, and outreach materials to train and assist aging network staff and volunteers to recognize fraud indicators, and enable aging network agencies to use various methods of outreach and public education to better inform older consumers and their families and enable them to report suspected cases. Held trainings for AAA staff and Volunteers, who then convened local forums.

General Issue: Environment

Cleanliness/ Pests

	LA	**2000** Complaints included annoyances and potential life threats: flies and ants, bedside toilets not emptied timely, whirlpools and rooms not cleaned or picked up.

Building/ Equipment

	DC	**2000** See Access to Facilities and Services: Admissions: Limited/No Licensed Facilities.
	LA	**2000** Ranging from safety and health hazards to inconveniences, problems included air conditioning and hot water; wheelchairs in need of repair; obstacles in hallways; hazardous supplies left unattended. The call light system can be inoperable, usually due to renovations or equipment failures. **Recommendation:** Facilities should have a plan for increased monitoring when call lights are out. Proper maintenance of equipment and vigilance are needed.
	MA	**2000** Large number of facility closures, some were 'free standing' NFs unable to continue for a variety of reasons including physical plant issues.
	MI	**1999** Sometimes the entire call light system does not work. **Recommendation:** Regular maintenance of the system.
	OR	**2000 Recommendation:** For NFs, need to identify their appropriate role, need for beds and their distribution, and resources for staffing and for updating physical plants.
	TX	**2000**. Older buildings (60% of NFs are more than 35 year-old) generate high maintenance efforts and costs, diverting funds from care and quality of life.
	WA	**1999** After a tragic fire at a licensed boarding home, eight residents perished. As a result, the state allotted loan money for some but not all local boarding homes to upgrade their fire safety systems. **Recommendation:** Increase funding to have sprinkler and other fire safety mechanisms in all boarding homes.

General Issue: Staffing

Job Related

Insufficient Staff	**AZ**	**2000** Insufficient staffing numbers and inadequate training; pay and benefits unattractive to recruit or retain staff; lobbying by NH industry. Legislative task force working on work force retention.
	CA	**1999** Proposed (did not become law) legislation addressed increased facility staffing and training. **2000** NF staffing shortages cause problems with resident quality of care. The state set aside $25 million for training grants to recruit, train and retain caregivers and healthcare professionals. The programs are expected to train 5,000 workers over 18 months. **Action:** Serve on the Training Initiative advisory council. **2001** LTC facilities, especially NHs have high staff turnover ratios, shortage of nursing staff, morale problems, lack of quality care and management problems. Staff often demonstrate negligent and abusive behaviors towards residents. **Recommendation:** Management training and support. Minimum nursing standards. Education and training programs including career-ladder programs for CNAs. Loan forgiveness and incentive programs for caretakers.

Insufficient Staff (cont.)	**CO**	**1999** There is a shortage of staff (CNAs and nurses), particularly well-trained staff. With virtually no unemployment, it is very difficult to attract workers to jobs with low pay and hard work, so almost anyone who applies is hired, resulting in inadequately prepared staff. **Recommendation:** A federal staffing ratio for CNAs to residents. **Action:** Started a group looking at solutions to the staffing problem and using best practices to address it (eg: get day care for children of staff). **2000** There is a shortage of staff (CNAs and nurses), particularly well-trained staff. Facilities are unable to recruit enough direct care staff and once trained, there is a high turnover rate, high rate of injuries, many "no-shows", and high stress and burn-out rates. **Recommendation:** Increase the state CNA to resident ratio and establish a federal ratio. Educate facilities that the best way to ensure quality care and attract consumers is to value their employees. Industry needs to increase wages and benefits, include CNA in resident care planning, assist in transportation and daycare, and provide educational opportunities and career ladders. **2001** Shortage of staff results in residents not being treated with respect and dignity, inadequate resident care (problems with staff unresponsiveness, resident hygiene, medication administration, nutrition, hydration, non assistance in eating, inadequate care planning, accidents), and abuse of residents. Contributors to staff shortages are low wages, lack of training and opportunities for advancement, staff turnover, and lack of staff support and supervision. **Recommendation:** Staff to resident ratios, adequate wages and resolution of the other contributors through improved training, availability of career ladders, and better supervision.
	CT	**1999** Staffing levels. **Action:** Directly and in coalition, pursued this issue with a legislative committee. Recommend changes in regulations to the health department. **2000** Despite increased resident care needs, staffing patterns have not increased within the health department standards. Unanswered call bells, delays in receiving meals and poor care, all often linked to lack of adequate staffing and supervision, are common complaints.
	DC	**1999** Staff shortages in NFs. Many resident care activities, such as bathing, feeding and general nursing care, are not getting done. Failure to provide basic services is resulting in repeated hospitalizations for bedsores, dehydration and malnutrition. Facilities are unable to recruit, adequately train and retain staff. **Recommendation:** Minimum resident-to-nursing staff ratios for all shifts. **2000** Staffing shortages in NFs. Recruitment, retention, training, supervision and a livable wage for nurse aides are some of the problem areas. A recent HCFA study noted there is a direct relationship between quality of care and staffing; facilities with less than two hours a day of aide care per resident have significantly more problems. **Recommendation:** Increase staffing ratios for all shifts through regulations. Establish a task force to examine workforce issues and wage enhancements through Medicaid wage pass-throughs or changes in the reimbursement formula.
	DE	**2001** Problems in recruiting and retaining staff. **Recommendation:** Statewide survey of nurses and CNA's. Further analysis and review of incentive programs to encourage recruitment and retention.
	FL	**2000** For six years understaffing has been the most frequently reported complaint for NHs. **Recommendation:** Raise minimum staffing requirements for NHs with minimum requirements per shift, not per 24 hour period. Adjust requirement upward for residents with higher nursing care needs.
	GA	**1999/2000/2001** For residents to receive quality care, the facility must provide sufficient, well-trained and well-supervised staff. When staffing is inadequate, residents may develop serious and avoidable medical problems, including malnutrition, dehydration, and pressure sores. **Recommendation:** State and federal laws and regulations should require - and the Medicaid budget should support - adequate direct care staff. **2001 Action:** LTCO was part of coalition which chose “Staffing in Nursing Homes” as a priority issue and sought funding from legislature to implement pilot projects on innovative staff recruitment and retention practices in NHs.
	IL	**2001** The lack of sufficient direct care staff to provide individualized resident care and prevent injury and illness is evidenced by the many complaints concerning confinement, dignity issues, lost/stolen personal property, accidents, unanswered call lights, inadequate care plans, medication problems, hygiene issues, unattended symptoms, menu/food problems, and shortage of staff. Staffing shortages stem in part from the low employment rate, low wage and low perception of job worth.

Insufficient Staff (cont.)	**KY**	**1999** Shortage of Staff **Action:** Formed coalition to draft legislation. **2000 Action:** Working with a committee looking at possible legislation on resident to staff ratios.
	LA	**1999&2000** Regulations currently require minimum staffing as follows: 2.6 hours per skilled resident and 2.35 per intermediate resident in a 24 hour period. NHs can exceed this yet still have significant care issues. Many complaints directly or intuitively referenced having insufficient, improperly trained or supervised staff. **2000** Sufficient staff is key to allowing staff the time and patience to provide care with dignity and respect. If staff have to leave residents on the toilet for an extended period to assist another resident or cannot spend time to work with a resident who is refusing care, neither basic physical care nor emotional well-being can be attended to. Complaints included ratios of 1 aide to 23 residents, inadequate weekend staffing, and insufficient staff to assure timely assistance with meals and prevent accidents. **2001** State requirements continue to be considerably lower than the optimal minimal level of 2.9 hours of CNA care, with additional levels for LPNs and RNs, associated with improved quality of life for residents. Family members and residents report being told that the facility is meeting the state staffing requirements while care needs go unmet. They are asking for a clear staffing ratio that establishes a minimum staff-to-resident ratio. **Recommendation:** Establish a task force on staffing. Ensure that staff receive a living wage and benefits and are adequately trained. Ensure models of care that make NHs better places to live and to work.
	MA	**1999** Sufficient numbers of staff, adequate training, supervision and support of staff in particular. Impacts quality of life and care. **2000** Staffing issues; lack of staff; poor staff training; poor staff retention. **2001** Staffing issues including short staffing, poorly trained staff, staff attitudes, communication with staff, failure of staff to meet basic needs.
	MD	**1999** The minimum staffing requirements promote poor care. There is a statewide shortage of nursing personnel and inadequate training for staff. A legislative task force convened to examine the current quality of care standards for NFs, staffing patterns and standards, and the ability of the labor pool to fill positions. **2000&2001** Problem areas persist affecting quality of care, including: minimum staffing requirements, low staff retention rates, limited pool of potential personnel, the inadequate training for staff and increased costs to the Medical Assistance program to meet the demands of legislation which was passed that increases direct care staff wages over three years by increasing the reimbursement rate for the Medicaid nursing cost center.
	ME	**1999 Action:** Submitted legislation (which was carried over) to raise the minimum standards for direct care staff and licensed staff, require facilities to post staffing information, and require a 1:3 ratio of caregivers to residents who are completely dependent on assistance during mealtime. **2000** Legislation passed raising minimum staffing to 1:5, 1:10, and 1:15. The definition of direct care was defined to mean hands-on care. Additional dollars were appropriated to raise the direct care wages for CNAs and nursing staff. **2001 Action:** To address short staffing, drafted a law (passed) providing 2.5% increase in wages and benefits for non-administrative home care agency personnel and requiring that NFs accepting the cost-of-living adjustment for '02 and '03 must increase salaries and benefits to all front-line employees by at least 3%.
	MI	**1999** Each year legislators propose staffing bills. Insufficient and overworked staff contribute to problems with medications. **Action:** Commented on this issue to media whenever possible. Encouraged the licensing department to visit facilities in the evening, holidays, and on week-ends when most short staffing occurs. Actively support the Eden Alternative, which will empower caregivers in decision making, and should result in staff retention. **2001** Petition to Congress to increase ratios of nurses and nursing assistants to residents. Local advocates collected 14,338 of the total 64,200 signatures presented.

Insufficient Staff (cont.)	**MN**	**1999** Many NHs closed down a portion of the facility or voluntarily placed a temporary ban on new admissions due to the shortage of staff. Some facilities explored recruiting staff from other countries. Legislation passed to: Allow workers from countries with extensive nursing assistant training programs to pass a competency test, instead of completing the 75 hour training; provide a 4% reimbursement increase in 2000 and another 3% in 2001; 80% of the funds must be used to increase wages. **2000** Residents were deeply affected by staff shortages. Overall quality of care suffered as facilities used temporary "pool" agencies to meet minimal staffing standards. Facilities voluntarily banned new admissions or closed down beds due to staff shortages. **Recommendation:** Update the state minimum staffing standard to reflect residents care needs. **Action:** Formed a coalition which recommended enacting: increased wages and benefits with means to ensure money goes to the workers; update of minimum staffing standards; fiscal disincentives for use of temporary nursing pools; and training curriculum update and incentives for career nursing assistants and career ladders. **Result:** Prior to receiving funds, facilities submitted plans for spending the wage pass through. Despite this, some staff reported no increases. **2001** Law passed ordering studies to determine appropriate ratios of nursing staff to residents and staff time needed to investigate possible resident maltreatment.
	MO	**1999** The state withdrew the very low staff-to-resident ratio from the regulations and required the facility to 'meet the needs of the resident.' **Action:** Watch the licensing and survey staff to see how they ensure facilities meet the new regulation. Plan to request a new higher ratio if the new regulation is not followed and cited. **2000** Presumably due to low occupancy, facilities accept residents with care needs or problems beyond the capabilities of the minimal number of staff.
	MS	**2000** Continued staffing shortage and inadequate staff training in NHs. Regulations were adopted to increase staffing ratios - 2.67 hours to 2.80 hours of direct nursing care per resident per 24-hours. **Action:** Monitor facilities and advocate for regulation changes to increase staffing ratios as needed. **2001** Overall neglect of basic resident needs seems to be increasing. Residents are often left in soiled diapers and have difficulty getting assistance when they require it. Non-ambulatory residents are left sitting or lying in bed for long periods of time because of insufficient staff. **2000&2001 Recommendation:** Increase adequate staffing enforcement and wages to recruit and retain staff. Replace Personnel Hours System (allows facility to use hours during the morning and/or afternoon shifts, neglecting resident needs during the night shift) with direct care staff-to-resident ratio regulations.
	NC	**1999&2000** Lack of or inconsistent staffing. The turnover rate continues to escalate from 100%+. Low unemployment rate and industry short term profit motives. **Action:** Held workshops or conferences to show appreciation for staff and encourage team work and continued education **2000** Industry try to minimally staff facilities to meet minimum requirements **2001** Increase in both technical assistance calls and complaints related to resident care. Affected by chronic staffing shortages.
	NH	**1999** Inadequate staffing is a difficult complaint to verify or identify as a contributing factor in care complaints. Facilities hire people not previously considered because of severe staffing needs made worse by lowest unemployment rate in the nation; low pay and benefits; poor LTC image; poor working conditions. **Recommendation:** Establish task force of stake holders throughout the health care field; identify new resources; build more positive image of health care/CNA work/career; work toward LTC facility culture change; support/encourage quality caregivers. See Enforcement: Survey-Related: Measure Outcome vs Cause. **2000** Resident falls increased dramatically, often due to inadequate staffing and supervision which causes excessive delays in responding to residents' needs or calls for assistance. Restraint use is a frequent practice because there are insufficient numbers of staff members to provide appropriate activities and to monitor residents. **2001** Inadequate and/or unstable staffing patterns in LTC facilities. **2000&2001** Insecure, bereft residents say trusted, beloved care-givers have quit. Elders are increasing while the workforce declines in part due to: low wages and benefits; difficult and unpleasant work; inadequate training and supervision; isolation from peers and support; work not respected or valued; and limited advancement opportunities. **Action:** Collaborate on Annual Nurse Aide Recognition Day. Provide technical assistance and support related to the staffing crisis. **Recommendation:** Culture Change initiatives to ease the workforce crisis and improve resident quality of life. Provide adequate wages and benefits. Develop advancement and certification opportunities. Provide adequate training and education. Develop support systems for direct care workers. Develop educational opportunities for nurses in nursing leadership, personnel management, mentoring, team building skills. Explore and develop appropriate additional and alternative health care workforce sources.

Insufficient Staff (cont.)	**NM**	**2000** A low staffing bill was vetoed. The state set a new staffing ratio of 2.3-2.5 hours per patient day, counting staff giving any hands on care, so the ratio has not made a significant difference. **Action:** Participate in a group with surveyors, industry representatives, advocates and consumers, that initiated the new staffing ratio. **2001** An optimal staffing bill based on the recommendations of the HCFA study was passed but vetoed by the governor
	NY	**2000** Increasing evidence of lack of critical staff and care with resulting incidences of abuse and neglect.
	OH	**1999** Complaints about staff shortages in RCFs became more frequent. In NHs, there are specific complaints of staff shortages and many complaints have staffing shortage as a causal factor. **Action:** Participate in review and revision of NH rules including the staffing requirement, along with other government, provider, and consumer representatives. **Recommendation:** A federal staffing ratio and update state staffing ratio **2000** Accidents, call lights unanswered, lack of personal hygiene, inadequate care plans and symptoms unattended can be directly linked to the lack of staff. **2001** Dignity/respect and hydration/nutrition complaints relate directly to facility staffing. New complicated and difficult to calculate NF rules require 2.75 hours of service to the average resident per day. **2000&2001** Lack of services correlates to the staff available to provide required care. There is a diminishing pool of available people to train or hire. Staff ratios are not a dominant part of the surveys, which measure outcomes not process. Medicaid budget increases and the need to balance NH versus community based care complicate the issue. Provider associations are effective lobbyists. **Action:** Participated on a committee to revise the NH rules and include an increase in the staffing ratio. Conducted letter writing campaigns, made media contacts, and contacted legislators to support staffing ratios in the rule revisions and in state legislation.
	OR	**1999** A major ALF corporation had significant quality care problems. Staff was insufficient and inadequately trained . Caregiver staff and administrative turnover was high. The corporate focus was on expansion more than day to day operations. **Action:** See Enforcement: Survey-Related: Ineffective Sanctions **2000** Low facility occupancy, residents with complex care needs, inadequate staffing and relatively low reimbursement contribute to facilities increased difficulty delivering and maintaining high quality care.
	RI	**1999** Staffing shortages - critical and also additional educational training **2000** Staffing shortages. Lack of CNAs. Problems with retention of trained personnel, low pay scales, and consistent and continuing education.
	TN	**1999** Continued and increased complaints related to basic resident needs, present as a result of under staffing, poor training and frequent turn over.
	TX	**1999** Despite a 3.7 % state increase in reimbursement rates designed to be directed towards staff expansions, staffing-related complaints persisted. Policy makers, advocates, and industry representatives continue to struggle with methods of achieving appropriate reimbursement while assuring accountability of funds. **2000** Securing and maintaining enough direct care staff to provide adequate care is a significant issue, with reimbursement methodologies as one gradient. **2001** The habitual problem of the last three years is direct care staffing. The current flat-rate reimbursement does not provide an incentive to hire additional staff or create services and benefits for residents beyond the very basic needs. **Recommendation:** Adopt facility-specific reimbursement based on expenses within certain categories, reimbursing for the actual care and services rendered. This is not likely to be adopted because of Medicaid and other state program deficits.
	UT	**1999** Some facilities really can't get the help they need and others use this as an excuse. ALFs now take more acute residents without increasing staff or expertise. **1999/2000/2001** Lack of staff and staff turnover/training issues. There is a shortage of CNAs and Nurses. **2001** Quality of care is directly linked to staffing. Lack of staff and staff training/turnover is the root of many of the complaints this year.
	VA	**2001 Action:** Worked with the legislature and various public and private groups to highlight the need for specific and meaningful staffing standards.

Insufficient Staff (cont.)	**VT**	**1999&2000** Increased complaints directly related to inadequate staffing in NHs. **Recommendation:** Establish state and federal minimum staffing standards. **2001** Problems continue despite new regulations requiring a minimum 3.0 hours direct care staff per resident per day averaged over a week. Residents/family members have difficulty determining if the facility meets this and there is concern that a facility can be significantly understaffed at times and still meet the minimum standard.
	WA	**1999/2000/2001** Residents continue to request requirements for adequate and sufficient staff. However, the department has refused to draft necessary regulations. **Recommendation:** Gather data supporting NCCNHR's staffing recommendations. Work with DSHS and facilities to improve the training for nurse aides. Work with facilities on ways to enhance job satisfaction and staffing patterns, such as assignments to particular residents, to foster a bond between the staff and residents.
	WV	**1999** Facilities are chronically under staffed. NHs refuse to hire more staff because they do not want or can not afford to hire additional staff. **Recommendation:** There should be more stringent staffing requirements imposed. **2001** Not enough staff in NHs to care for residents, staff poorly trained or not motivated, high staff turn over. Resistance to increase minimum staffing levels by the industry and certain governmental agencies, possibly due to shortage of funds to pay for more staff. Lack of respect shown to CNA staff. **Recommendation:** Increase minimum staffing levels. Mandate that CNAs be included in care planning. Serious attention to Eden Alternative, Pioneer practices.
	WY	**2001** A continuing concern is the shortage of well-trained, compassionate staff. The lack of staff has a direct impact on the residents' quality of life.
Use of Agencies/ Pool Personnel	**CO**	**2000** Many facilities rely heavily on pool agency staff who are unfamiliar with the residents. **2001** Use of pool staff, unfamiliar with residents needs and behaviors, is a contributor to resident abuse and residents not being treated with respect and dignity.
	CT	**2000** Criminal background checks of licensed/certified NH staff, especially direct care staff. **Recommendation:** Establish more stringent guidelines, which must include direct care staff furnished by temporary and nursing pool agencies.
	MN	**2000** Quality of care really suffered as more facilities, even in rural areas, used temporary “pool” agencies to meet minimal staffing standards. See Insufficient Staff
	NH	**1999** There are no figures collected to identify unacceptable risk factors, such as percent of agency personnel utilized at any point in time. **Recommendation:** See Enforcement: Survey-related: Measure Outcomes vs Cause**.** **2000&2001** RCFs/ALFs have a high utilization of temporary (agency) staff. Heavy use of temporary personnel, RNs as well as CNAs, places these direct care-givers in positions for which they are not well prepared because they are not currently, in most instances, afforded opportunities to learn about providing proper care for persons with dementing illnesses. This situation is detrimental and hazardous to both the resident and the care-giver.
Staff Lack Training	**AZ**	**2000** Inadequate training. See Insufficient Staff.
	CA	**2000&2001** See Insufficient Staff.
	CO	**1999&2000** There is a shortage of staff (CNAs and nurses) and an even greater shortage of well-trained staff. See Insufficient Staff. **2001** Lack of training is a barrier to adequate resident care and contributes to resident abuse. Staff training would help solve staff shortages (see Insufficient Staff). **Recommendation:** Provide residents rights training to ensure residents are treated with respect and dignity and in what constitutes abuse and how to report it.
	DC	**1999** Inability of NFs to recruit, adequately train and retain staff. **Recommendation:** continuous training of NH staff **2000** Recruitment, retention, training, supervision and a livable wage for nurse aides are some of the problem areas. See Insufficient Staff.
	GA	**1999/2000/2001** For residents to receive quality care, the facility must provide sufficient, well-trained and well-supervised staff. See Insufficient Staff.

Staff Lack Training (cont.)	**HI**	**1999** Most facilities, those under 120 beds, are not required by federal law to hire licensed social workers, resulting in increased hiring of social service designees without training or understanding of strong advocacy for residents. **Action:** Worked with university gerontology program to improve the curriculum, encourage social work students to enter gerontology, and provided mini-workshops for those working as social workers in NHs without an academic background in social work.
	KS	**1999/2000/2001** CNA jobs are becoming more difficult and stressful as more residents suffer from dementia and dementia-related disorders, such as Alzheimer's disease. Residents are more acutely ill while the budgets of most facilities are tightening. **Recommendation:** Additional periodic formal training for CNAs on the subjects of stress, effective communication with other staff members and improvement in the care of residents with increasingly demanding care needs. Direct state agencies to examine statutes, rules, and regulations and identify funds which may be available for training, retraining or continuing education of staff.
	KY	**2000&2001 Action:** Working to provide training for B&C homes across the state.
	LA	**1999** Many of the problems reported are intuitively related to having insufficient, improperly trained or supervised staff. **2000** Complaints included rough handling by aides; residents exposed during treatment or bathing; staff responding rudely to requests for assistance; and being spoken to rudely. **Recommendation:** Training on stress reduction, the influence of words/actions on residents, and opportunities for upholding resident dignity and humanity, such as how: the resident is addressed and approached; questions are answered; choice is encouraged in even small ways; touch is used; privacy is ensured; and attention is paid to the resident during care routines. **2001 Recommendation:** Ensure that front line staff are adequately trained.
	MA	**1999** Sufficient numbers of staff, adequate training, supervision and support of staff in particular. Impacts quality of life and care. **2000** Staffing issues; lack of staff; poor staff training; poor staff retention. **2001** Staffing issues including short staffing, poorly trained staff, staff attitudes, communication with staff, failure of staff to meet basic needs
	MD	**1999** The minimum staffing requirements continue to promote poor care. There is a statewide shortage of nursing personnel and there is inadequate training for staff. **2000&2001** Inadequate training for staff. See Insufficient Staff
	MI	**1999** Constant turnover in competency evaluated nursing aides (CENAs), along with a shortage of properly trained staff, contributes to accidents and improper handling. Aides are overworked, underpaid and 'under respected.' **Recommendation:** In-services to LTC employees, with monitoring by the state.
	MN	**1999** See Insufficient Staff. **2000 Recommendation:** Update state staff training curriculum to reflect front line staff survival skills and dementia skills training for all staff. See Insufficient Staff. **2001** Legislature passed to provide and more training opportunities for NH workers and scholarships and English as a second language courses for staff.
	MS	**2000** Staffing shortage and inadequate staff training in NHs is a continuing problem.
	NC	**2000** Direct care staff are not appreciated, educated and respected. **Action:** Worked with broad coalition on conferences specifically about culture change and how it can be implemented to improve the lives of residents and staff alike.
	NH	**2000&2001** Frequently inadequate training and education to fulfill the diverse expectations and requirements of the job. See Insufficient Staff.

Staff Lack Training (cont.)	**OR**	**1999** See Insufficient Staff **2000** New staff passing medications without proper training or instructions by a nurse. Unqualified staff passed medications but documented that a qualified staff person administered them. Sometimes unlicensed personnel train other unlicensed personnel. Facility administrators charged with developing a safe medication administration system need more experience and training. Better screening is needed of the RNs hired by facilities to educate and instruct unlicensed personnel.
	RI	**1999** Staffing shortages - critical and also additional educational training **2000** Staffing shortages. Lack of CNAs. Problems with retention of trained personnel, low pay scales, and consistent and continuing education.
	TN	**1999** Continued and increased complaints related to basic needs of residents, present as a result of under staffing, poor training and frequent turn over.
	UT	**1999/2000/2001** Lack of staff and staff turnover/training issues. There is a shortage of CNAs and nurses. **2001** Quality of care is directly linked to staffing. Lack of staff and staff training/turnover is the root of many of the complaints this year.
	VT	**1999** Many care complaints are directly related to the lack of well trained and well supervised staff.
	WA	**1999&2000 Action:** In 1997, worked with care provider associations, resident advocacy groups, and state agencies in a task force to address training problems in adult family homes and boarding homes. Documented an alarming number of safety and care problems related to insufficiently trained staff. Legislation to address these issues directed pertinent state agencies to work with providers, consumer groups, and others to submit specific recommendations on training standards and a training/educational system to the legislature, including specialty training for care of residents with dementia, mental illnesses, and developmental disabilities, and training modules creating a career path towards certification as a Nursing Assistant. **2001** Continue to work with DSHS and facilities to improve the training for nurse aides.
	WV	**1999** Staff are often not appropriately trained. Facilities frequently do not see the need for better trained staff. **Recommendation:** More stringent training requirements. **2001** Little time taken to train staff adequately. See Inadequate Staff. **Recommendation:** Serious attention to Eden Alternative, Pioneer practices.
	WY	**2001** A continuing concern is the shortage of well-trained, compassionate staff. The lack of staff has a direct impact on the residents' quality of life.
Need Training on Dementia/ Similar	**CO**	**2000** CNAs are often not trained on how to interact with residents with dementia and other special needs.
	IL	**2001** Given the mix of residents with serious mental illness in geriatric facilities, the CNA needs to know how to care for alert but disabled seniors, seniors with dementia, and people (both young and old) with mental illness who need active psychiatric rehabilitation. CNAs do not have this knowledge base.
	MI	**2000** See Access to Facilities and Services: Access to Services: Dementia/Mental Illness.
	MN	**2000 Recommendation:** Update state staff training curriculum to reflect front line staff survival skills and dementia skills training for all staff. See Insufficient Staff.
	MT	**2000** See Access to Facilities and Services: Access to Services: Dementia/Mental Illness.

Need Training on Dementia/ Similar (cont.)	**NH**	**1999** Inadequate specialized training for licensed nurses and CNAs in understanding and providing appropriate care for residents with dementing illnesses. Limited human resources to provide education and training in this specialized area. Failure of many facilities to adequately educate, train and supervise their staff in the nature of dementia and appropriate means, modes and methods of providing both quality care and quality of life for these individuals. **Recommendation:** See Access to Facilities and Services: Access to Services: Dementia/Mental Illness. **2000** A popular nursing assistant textbook addresses physiology, not resident care. RCFs/ALFs have many residents with dementia and each facility determines what training and education staff require; most of the "trainers" are untrained. **2000&2001** Inadequate or absent education/training opportunities for nurses and direct care givers in providing appropriate care for individuals with dementing illnesses. **Recommendation:** Develop a state-wide education program in the proper care of persons with dementing illnesses. Develop emerging culture change initiatives which have opportunities for staff to develop expertise in the area of dementia care. Develop career ladders that include training and financial recognition for persons who develop expertise. Identify state agencies providing temporary health care personnel and have such people receive education and training to include the principles of validation, the notion of environmental "triggers" of agitated behaviors, methods to prevent agitated behaviors, and appropriate intervention techniques when agitation does occur. Create advanced certification programs in the area of dementia care.
	OH	**2000** ACF providers have not been trained sufficiently to identify the problems of those needing MH services, and required services are not always sought.
	WA	**1999&2000** See Staff Lack Training.
Training not used in Practice	**TN**	**1999** A recent CNA trainee discontinued her training because the practices of proper care taught in the classroom were routinely ignored once she began her clinical training on the floor. Another CNA completed the entire training course, but resigned soon after being placed for the same reason.
Low Wages/ Benefits	**AZ**	**2000** Pay and benefits unattractive to recruit or retain staff. See Insufficient Staff.
	CO	**1999** The state has a booming economy with virtually no unemployment, so it is very difficult to attract workers to an industry that requires hard work at low pay. **2000** CNAs do not receive a livable wage and affordable benefits. **Recommendation:** The industry needs to increase wages and benefits. **2001** See Insufficient Staff.
	DC	**2000** Recruitment, retention, training, supervision and a livable wage for nurse aides are some of the problem areas. See Insufficient Staff.
	IL	**2000** Fewer people seek positions as direct care workers in NHs, and those often change facilities to obtain better working conditions, wages or benefits. **Action:** Promote Pioneer practices as a means to recruit and retain staff. Used program training dollars to present workshops across the state, aimed at NH administrators and directors of nursing. Presentations included culture change and bathing techniques for residents with dementia. Initiated meetings with providers to discuss the implementation of Pioneer practices. **2001** Staffing shortages stem in part from the low employment rate, low wage and low perception of job worth. See Insufficient Staff.
	KS	**1999/2000/2001** Low wages are causing high turnover in ACHs. **Recommendation:** Ensure reimbursement rates are adequate to provide an optimal level of services to NH residents. Wage pass-through legislation should be made permanent so that facilities can adequately compete for employees.
	LA	**2001 Recommendation:** Ensure that staff receive a living wage and benefits. See Insufficient Staff.
	MD	**2000** Legislation was passed that will increase direct care staff wages over three years by increasing the reimbursement rate for the Medicaid nursing cost center. **2001** Legislation to improve the wages and benefits for the direct care staff in NFs may be impeded by the deficits in the Medical Assistance Program budget.

Low Wages/ Benefits (cont.)	**ME**	**2000** Additional dollars were appropriated to raise the direct care wages for CNAs and nursing staff. **Recommendation:** DHS must reconsider the provision that allows NFs to retain 25% of cost savings in the direct care component. **2001 Action:** To address short staffing, LTCOP drafted law then passed with 2.5% increase in wages and benefits of non-administrative home care agency personnel and provides that NFs accepting the cost-of-living adjustment for '02 and '03 must increase salaries and benefits to all front-line employees by at least 3%.
	MI	**1999** Aides are overworked, underpaid and 'under respected.'
	MN	**1999** See Insufficient Staff**.** **2000** Increased wages and benefits are clearly needed, but even the smallest increase to workers costs the state millions. **Action & Result:** See Insufficient Staff . **2001** Legislature passed another 3% wage pass through COLA to provide salary increases for NH workers.
	MS	**2000&2001** See Insufficient Staff. **Recommendation:** Increase wages to properly recruit and retain good staff.
	NH	**1999/2000/2001** Low wages and benefits. **Recommendation:** Provide adequate wages and benefits. See Insufficient Staff.
	RI	**2000** Staffing shortages. Lack of CNAs. Problems with retention of trained personnel, low pay scales, and consistent and continuing education.
	UT	**2001** There is a shortage of CNAs, in part due to lack of benefits and facilities' unwillingness to pay the CNAs better wages.
	WA	**1999 Action:** Chair task force to review problems such as poor wages for providers. **2000 Action:** Work in alliance to increase caregiver wages from in-home care through NH care. **Recommendation:** Increase caregiver wages at least $1 per hour per year to double the minimum wage.
High Staff Turnover	**AZ**	**2000** Insufficient staffing numbers and inadequate training; pay and benefits unattractive to recruit or retain staff; lobbying by NH industry. Legislative task force working on work force retention.
	CA	**2000&2001** See Insufficient Staff.
	CO	**2000** Facilities unable to recruit enough direct care staff and once trained, there is a high turnover rate and high burn-out rates. **Recommendation:** See Insufficient Staff **2001** High staff turnover is a contributor to residents not being treated with respect and dignity and to resident abuse. With high staff turn-over, abusers move from one facility to another before proper investigation. See Insufficient Staff.
	DC	**1999** Inability of NFs to recruit, adequately train and retain staff. See Insufficient Staff. **2000** Recruitment, retention, training, supervision and a livable wage for nurse aides are some of the problem areas. See Insufficient Staff.
	DE	**2001** See Insufficient Staff.
	IL	**2000** See Low Wages/Benefits.
	KS	**1999/2000/2001** Low wages are causing high turnover in ACHs. **Recommendation:** See Low Wages/Benefits.
	MA	**2000** Staffing issues; lack of staff; poor staff training; poor staff retention.
	MD	**2000&2001** Problem areas persist which affect quality of care including low staff retention rates. See Insufficient Staff.

High Staff Turnover (cont.)	**MI**	**1999** Constant turnover in competency evaluated nursing aides (CENAs), along with a shortage of properly trained staff, contributes to accidents and improper handling.
	NC	**1999&2000** See Insufficient Staff.
	NH	**1999** There are no figures collected to identify unacceptable risk factors such as turnover rate or the number of vacant direct care and nursing positions at any point in time. **Recommendation:** See Enforcement: Survey-related: Measure Outcomes vs Cause**.** **2000&2001** See Insufficient Staff and Need Training on Dementia/Similar.
	NV	**2000** Constant nursing staff turnover in skilled NFs. Problems in the recruitment and retention of staff, particularly licensed nurses. An acute shortage of RNs. **Recommendation:** Legislative review. **Action:** Continue to make presence known at facilities where problems are identified.
	OR	**1999** See Insufficient Staff. **2000** High staff turnover exacerbates problems surrounding the administration of medications, making it more difficult to coordinate staff with limited nurse availability.
	PA	**1999 Result:** A restraint-free facility highlighted in the news said that eliminating the use of restraints has 'led to happier residents and was a major factor in reducing the annual employee turnover rate from about 30% to 16%'. See Residents Rights: Neglect/Abuse: Restraints.
	RI	**2000** Staffing shortages. Lack of CNAs. Problems with retention of trained personnel, low pay scales, and consistent and continuing education.
	TN	**1999** Continued and increased complaints related to basic needs of residents, present as a result of under staffing, poor training and frequent turn over.
	UT	**1999/2000/2001** Lack of staff and staff turnover/training issues. There is a shortage of CNAs and Nurses. **2001** Quality of care is directly linked to staffing. Lack of staff and staff training/turnover is the root of many of the complaints this year.
	WV	**2001** See Inadequate Staff.
Difficult Work	**CO**	**1999** The state has a booming economy with virtually no unemployment, so it is very difficult to attract workers to an industry that requires hard work at low pay. **2000** Facilities are unable to recruit enough direct care staff and once trained, there is a high turnover rate, high rate of injuries, many "no-shows", and high stress and burn-out rates. CNAs are expected to take care of too many residents (are working “short staffed") **Recommendation:** See Insufficient Staff.
	KS	**1999/2000/2001** See Staff Lack Training.
	MI	**1999** Aides are overworked, underpaid and 'under respected.'
	NC	**1999** Industry image as a difficult dangerous workplace. **Action:** Held workshops/conferences for staff to provide education, support, and empowerment. Encourage and assist in setting up support groups. Working to have positives of facilities addressed by media.
	NH	**1999** Poor working conditions. **Recommendation:** See Insufficient Staff**.** **2000&2001** Difficult and often unpleasant work environment. **Recommendation:** See Insufficient Staff.
	UT	**2001** There is a shortage of CNAs, in part due to poor working conditions.

Lack of Recognition	**CO**	**2000** CNAs are unrecognized for the important work they do and their knowledge of individual residents. **Recommendation:** See Insufficient Staff.
	IL	**2001** Staffing shortages stem in part from the low employment rate, low wage and low perception of job worth. See Insufficient Staff.
	MI	**1999** Aides are overworked, underpaid and 'under respected.' **2001 Action:** Helped plan two nursing assistant conferences to recognize them and provide further education on their role in providing respect and services to residents.
	NC	**2000** Direct care staff are not appreciated, educated and respected. **Action:** Held workshops/conferences to show appreciation for staff and encourage team work and continued education. Worked in broad coalition on conferences about culture change and how it can be implemented to improve the lives of residents and staff alike.
	NH	**2000** Isolation from peers and peer support, both internal and external to their facility. The work is not generally respected or valued by the public at large, other employees in the health care field or, all too often, the leadership of the facility. **Recommendation:** Culture change initiatives. Collaborate with the provider associations to produce Nurse Aide Recognition Day. Develop support systems for direct care workers.
	WV	**2001** Lack of respect shown to CNA staff. See Inadequate Staff.
No Career Advance-ment	**CA**	**2000&2001** See Insufficient Staff.
	CO	**2000&2001 Recommendation:** Provide educational opportunities and career ladders for employees. See Insufficient Staff.
	MN	**2000 Recommendation:** Update the training curriculum and provide incentives for career nursing assistants and career ladders. **Action:** See Insufficient Staff. **2001** Legislature passed to provide and more training opportunities for NH workers and scholarships and English as a second language courses for staff.
	NH	**1999 Recommendation:** Build more positive image of CNA work and health care as a career. Work toward culture change. **2000&2001** Limited or absent opportunities for growth and advancement, both within their chosen field and beyond it. **Recommendation:** Culture change initiatives. Develop advancement opportunities within the direct care field. Develop career ladders with training and financial recognition for expertise in dementia care-giving.
	WA	**1999&2000 Action:** See Staff Lack Training.
Staff Lack Supervision	**CA**	**2001** See Insufficient Staff.
	CO	**2001** See Insufficient Staff.
	CT	**2000** Unanswered call bells, delays in receiving meals and poor care, often linked to lack of adequate staffing and supervision, are common complaints.
	DC	**2000** Recruitment, retention, training, supervision and a livable wage for nurse aides are major problem areas.
	GA	**1999/2000/2001** For residents to receive quality care, the facility must provide sufficient, well-trained and well-supervised staff.
	LA	**1999** Many of the problems reported are intuitively related to having insufficient, improperly trained or supervised staff.
	MA	**1999** Sufficient numbers of staff, adequate training, supervision and support of staff in particular. Impacts quality of life and care.
	MD	**2000** Issues in licensed ALFs include lack of supervision, resident care issues, financial exploitation by providers, safety issues, and contract concerns.

Staff Lack Supervision (cont.)	**MS**	**2000** For residents to receive good quality care they need and deserve, NHs must have adequate, well-trained, and well-supervised staff. See Insufficient Staff.
	NH	**1999&2000** Inadequate initial and on-going training and supervision for staff exacerbate challenging behavior problems in residents with dementia. **2000** Resident falls have increased dramatically, many times due to inadequate supervision and inadequate staffing causing excessive delays in responding to residents' needs or calls for assistance. **Recommendation:** Culture change initiatives. Develop educational opportunities for nurses in the areas of nursing leadership, personnel management, mentoring, team building skills and the like. See Insufficient Staff.
	OR	**2000** See Insufficient Staff.
	VT	**1999** Many care complaints are directly related to the lack of well trained, and well supervised staff.
Increased Patient Acuity	**IL**	**2001** See Staff Lack Training.
	KS	**1999/2000/2001** See Staff Lack Training.
	MO	**2000** Presumably due to low occupancy, facilities accept residents with care needs or problems beyond the capabilities of the minimal number of staff.
	NH	**2000** The elderly requiring NH care continue to follow the trend of being “older and sicker”. Many have a dementing illness, in addition to presenting with complex and multiple medical conditions. See Insufficient Staff and Need Training on Dementia/Similar.
	NJ	**1999/2000/2001** As facilities provide more specialized care, reports arise of abuse and neglect that used to be limited to acute care hospitals.
	OH	**2001** NF residents now have a higher level of need due to earlier hospital discharges and extension of life expectancy from improved medical interventions.
	OR	**2000** Low facility occupancy, residents with complex care needs, inadequate staffing and relatively low reimbursement all contribute to the problem that facilities are having increasing difficulty delivering and maintaining high quality care.
	UT	**1999** ALFs take more acute residents than in the past without an increase in staff numbers or expertise.
Labor pool issues		
	CO	**1999** See Job Related: Insufficient Staff.
	DE	**2001** World-wide nursing shortage. **Recommendation:** Further analysis and review of incentive programs to encourage recruitment and retention.
	IL	**2001** Staffing shortages stem in part from the low employment rate, low wage and low perception of job worth. See Job Related: Insufficient Staff.
	KS	**1999/2000/2001** Due to the tight labor market, ACHs have serious difficulty attracting and retaining good workers. **Recommendation:** See Low Wages/Benefits.
	MD	**1999** There is a statewide shortage of nursing personnel. See Job Related: Insufficient Staff. **2000&2001** Problem areas which affect quality of care include: limited pool of potential personnel. **Action:** See Job Related: Insufficient Staff.
	NC	**1999&2000** Low unemployment rate. See Job Related: Insufficient Staff.
	NH	**1999** Lowest unemployment rate in the nation. Competing for the same existing poor labor. See Job Related: Insufficient Staff.

Labor pool issues (cont.)	**NV**	**2000** An acute shortage of RNs. See Job Related: High Staff Turnover.
	OH	**2000&2001** There is an ever-diminishing pool of available people to train or hire as nursing assistants.
	UT	**1999/2000/2001** Lack of staff and staff turnover/training issues. There is a shortage of CNAs and nurses.
	VT	**2001** There is a shortage of certified direct care workers. **Action:** Participated in a state study group to examine ways to recruit train and retain direct care workers.
Allocation of Reimbursement Funds for Staffing		
	KS	**1999/2000/2001 Recommendation:** Wage pass-through legislation should be made permanent so that facilities can adequately compete for employees.
	MD	**2000** Legislation was passed that will increase direct care staff wages over three years by increasing the reimbursement rate for the Medicaid nursing cost center. **2001** Legislation to improve the wages and benefits for the direct care staff in NFs may be impeded by the deficits in the Medical Assistance Program budget.
	ME	**2000** Additional dollars were appropriated to raise the direct care wages for CNAs and nursing staff. **Recommendation:** DHS must reconsider the provision that allows NFs to retain 25% of cost savings in the direct care component. **2001 Action:** To address short staffing, LTCOP drafted law then passed with 2.5% increase in wages and benefits of non-administrative home care agency personnel and provides that NFs accepting the cost-of-living adjustment for '02 and '03 must increase salaries and benefits to all front-line employees by at least 3%.
	MN	**1999 Action:** Legislation was passed to provide a 4% reimbursement increase in 2000 and another 3% in 2001; 80% of the funds must be used to increase wages. **2000 Action:** Formed a coalition on staffing issues which recommended ensuring that new money spent reaches direct care workers. **Result:** Facilities had to submit plans for spending the wage pass through for approval prior to receiving the funds. Despite this, some staff reported that no increases were received. **2001** Legislature passed another 3% wage pass through COLA to provide salary increases for NH workers.
	NM	**2001** An optimal staffing bill based on the recommendations of the HCFA study was passed but not signed by the governor.
	TX	**1999/2000/2001** See Job Related: Insufficient Staff.
	WA	**2000 Action:** Work in alliance to increase caregiver wages from in-home care through NH care. **Recommendation:** Increase caregiver wages at least $1 per hour per year to double the minimum wage.
Resistance to Adequate Staffing Ratios		
	CO	**1999 Action:** Exploring state legislation to require a staffing ratio but given the opposition to a staffing ratio by the industry are not hopeful that this will be passed.
	MO	**1999 Action:** The state recently withdrew the staff-to-resident ratio and required the facility to 'meet the needs of the resident.' The previous ratio was very low, and there was no hope of getting that ratio increased.
	NM	**2000&2001** See Job Related: Insufficient Staff.
	WA	**1999/2000/2001** Residents continue to request requirements for adequate and sufficient staff; however, the department has refused to draft necessary regulations.
	WV	**2001** Resistance to increase minimum staffing levels by the LTC industry and certain governmental agencies. See Job Related: Insufficient Staff.

General Issue: Patient Care (also see Staffing: Job Related: Insufficient Staff)		
Food / Nutrition Related		
Eating Assistance	**CO**	**2001** Nutrition and hydration issues and assistance in eating. See Insufficient Staff.
	GA	**1999** Lack of assistance with eating contributes greatly to persistent and critical problems of malnutrition and dehydration among many NH residents.
	LA	**2000** Individual complaints included insufficient staff to assure timely assistance with meals.
	MA	**1999** Failure of staff of facilities to provide assistance with eating and drinking.
	MS	**2000** Malnutrition and dehydration are persistent and critical among many NH residents. Lack of help with eating contributes considerably to this problem.
	TN	**1999** Continued and possibly increased complaints related to basic needs of residents, including lack of assistance in feeding.
Menu	**IL**	**2001** High number of complaints concerning menu/food problems. See Staffing: Job Related: Insufficient Staff.
	LA	**2000** Complaints included food prepared to taste or poor texture; required substitutions not available; and inadequate amounts. **Recommendation:** Some facilities have gone to buffet style meals; some have made snacks available around the clock in places that are readily accessible to the residents.
	MI	**1999** Problems with Food/Menu (predominately a B&C issue)- inappropriate/unattractive menu choices.
	OR	**2001** Increasing food complaints in ALFs, including food served cold, lack of variety and alternatives, small portions, nutritionally unbalanced, high sodium, lack of diabetic desserts, no fresh fruits and vegetables, overcooked and dry meats, thin soups and unappetizing presentation. Contributing factors include inadequate food budgets, administrators with little or no training in food service and how to hire a cook, and unqualified individuals hired as facility cooks.
Malnutrition or Dehydration	**CO**	**2001** Nutrition and hydration issues and assistance in eating. See Insufficient Staff.
	DC	**1999** Failure of NFs to provide basic services is resulting in repeated hospitalizations of residents for bedsores, dehydration and malnutrition.
	GA	**1999** Lack of assistance with eating contributes greatly to persistent and critical problems of malnutrition and dehydration among many NH residents.
	MA	**1999** Failure of staff of facilities to ensure residents receive adequate hydration and nutrition. Failure to provide access to sufficient fluids.
	ME	**2000 Recommendation:** Provision of best practices forums - DHS must participate in a series of best practice forums with advocacy agencies and providers which has resulted in one day forum designed for NF training coordinators on Nutrition and Hydration Care.
	MS	**2000** Malnutrition and dehydration are persistent and critical among many NH residents.
	OH	**2001** Complaints regarding hydration and nutrition remain high; these are likely directly related to the staffing ratios in facilities.
	TN	**1999** Continued and possibly increased complaints related to basic needs of residents, including lack of proper hydration.
	VT	**1999** Many individuals living in NH and residential care homes do not receive adequate hydration.

Quality

CA	**2001** See Insufficient Staff.
CO	**2001** Inadequate resident care. See Insufficient Staff.
CT	**2000** Complaints of unanswered call bells, delays in receiving meals and poor care often linked to lack of adequate staffing and supervision, are common problems.
DC	**1999** Many resident care activities, such as bathing, feeding, and general nursing care, are not getting done. **2000** Problems confronting residents of Community Residence Facilities (especially for the mentally ill) are related to the unhealthy and unsafe physical environment in which they live; the poor level of care and services they receive; the failure of providers and agencies to respect residents' rights; and resident financial, mental and physical abuse and neglect. **Recommendation:** See Enforcement: Survey Related: Lenient/Inadequate Enforcement.
ID	**2000** The state implemented an aged and disabled waiver and changed ALF regulations to allow more seriously ill elders; complaints are rising regarding quality of care. **2001** State Medicaid waiver program allows NH level of care in Assisted Living (>5 beds) or Certified Family Homes (<5 beds). Increasing enrollment, statewide inconsistencies in administration, and minimal certification and monitoring systems raise many concerns regarding quality of care and oversight.
IL	**2001** See Staffing: Job Related: Insufficient Staff.
LA	**1999&2000** Problems with: Accidents, improper handling; personal hygiene; wandering/failure to accommodate; abuse/gross neglect; pressure sores; symptoms /changes unattended; range of motion, ambulation; physical restraint; assistance in eating or assistive devices; fluid availability/dehydration; weight loss due to inadequate nutrition. **2001** Family members and residents report that they are too often told that the facility is meeting the state requirements for staffing while care needs go unmet. **Recommendation:** Ensure models of care that make NHs better places to live and to work. See Staffing: Job Related: Insufficient Staff.
MA	**2000** Quality of resident care; resulting quality of life issues such as unanswered call bells, requests for assistance. **2001** Staffing issues including short staffing, poorly trained staff, staff attitudes, communication with staff, failure of staff to meet basic needs.
MD	**1999&2000** Both state and federal reports identified serious problems with the quality of care in NFs. **2000** Problems in ALFs include resident care issues. **2001** Quality care problems are reflected by increased complaints about resident care, including accidents, care planning, responsiveness of staff, and personal hygiene. **Action:** To inform family members and enlist their assistance in promoting quality care, many local LTCOPs worked with the National Citizens' Coalition for Nursing Home Reform's Family Council Project. The project staff conducted training in several counties on the development or enhancement of family councils. Also, participated on a task force, which launched the Nursing Home Report Card on the Internet to provide consumers with current information regarding NFs, including the results of surveys based on quality of care indicators, resident profiles, and specialized searches for specialized needs.

Quality (cont.)	**MI**	**2000** NHs fail to: change their systems, practices and procedures to effectively solve care issues and prevent repeated deficiencies for poor care; condemn poor care and promote quality care and quality of life; manage themselves in a fiscally prudent manner; provide quality care on a continuous basis, so individuals are drawn to the facility, thereby keeping the census up, and sufficient money flowing into the home. When the home is full, staff tend to have better pay and working conditions and residents receive better care, and the cycle continues. **Action:** Support bringing the Eden Alternative and other best practices to NHs. **2001 Action:** LTCOP helped plan two nursing assistant conferences to recognize them and provide further education on their role in providing respect and services to residents. **Recommendation:** To address care related complaints, LTCOP proposed "Staffing Solutions WorkGroup," including representation by direct health care workers, facilities, advocates, consumers, regulators, disability organizations and various government officials.
	MN	**2001** Legislation passed to develop quality profiles of LTC providers to enable consumers to make comparisons. Profiles for NH providers will be completed in 2002, those for other providers in 2003.
	MS	**2001** See Response Time.
	NC	**2001** Increase in both technical assistance calls and complaints related to resident care. Affected by chronic staffing shortages.
	NH	**2000** RCFs had significant issues concerning the quality of care. See Access to Facilities and Services: Transfer and Discharge: Assisted Living, B&C, Similar.
	NM	**2001 Action:** Participated in a state-mandated study on deaths in LTC facilities to identify cases implicating inadequate care as a contributing factor in the death.
	TN	**1999** Continued and possibly increased complaints related to basic needs of residents indicative of poor quality of care.
	UT	**2001** Quality of care is directly linked to staffing. Lack of staff and staff training/turnover is the root of many of the complaints this year.
	WA	**2000** Payment for care in the Medicaid waiver programs is very poor, resulting in poor care, neglect, poorly paid staff. Providers got the legislature to authorize a state study of potential payments based on resident acuity level (similar to NHs). **Recommendation:** Adequate funding for Medicaid waiver levels of care.
	WY	**2001** When residents don't receive adequate care and are transferred to a facility that provides good care, their prior lack of care and health issues prove costly.
Toileting/ Inconti-nence	**LA**	**2000** Complaints included residents left wet or soiled with feces which can be extremely embarrassing for the resident, and if left unattended, can contribute to skin breakdown. For this reason, facilities are required to provide assistance to residents who need it in a timely fashion and to keep them clean and free of odor.
	MS	**2001** See Response Time.
	OH	**2000** The survey agency reports an increase in bowel incontinence, bladder incontinence and pressure sores.
Symptoms Unattended	**IL**	**2001** High number of complaints concerning unattended symptoms. See Staffing: Job Related: Insufficient Staff.
	MI	**1999** Symptoms Unattended- relates to care plan issues; an incomplete assessment or unused care plan do not facilitate proper monitoring of resident conditions, or changes. **Action:** Developed/distributed a 'fact sheet' and discuss the right to question care or unattended symptoms one-on-one with concerned callers.
	OH	**2000** Accidents, call lights unanswered, lack of personal hygiene, inadequate care plans, and symptoms unattended can be directly linked to the lack of staff.

Sores	**DC**	**1999** Failure of NFs to provide basic services is resulting in repeated hospitalizations of residents for bedsores, dehydration and malnutrition.
	OH	**2000** The survey agency reports an increase in bowel incontinence, bladder incontinence and pressure sores.
Response Time	**CO**	**2001** Residents call lights and requests for assistance go unanswered. See Insufficient Staff.
	CT	**2000** Complaints of unanswered call bells, delays in receiving meals and poor care often linked to lack of adequate staffing and supervision, are common problems.
	IL	**2001** High number of complaints concerning unanswered call lights, requests for assistance problems. See Staffing: Job Related: Insufficient Staff.
	LA	**2000** Complaints included call lights answered late or not at all; and call bells out of the resident's reach. Failure to answer timely can result in forced incontinent episodes for residents otherwise able to toilet with assistance; and can lead to severe injuries to residents who attempt transfer without assistance.
	MA	**2000** Quality of resident care; resulting quality of life issues such as unanswered call bells, requests for assistance.
	MD	**1999** Cases reported included resident-to-resident abuse, falls, response times, and other categories, have raised serious concerns about the quality of care. A legislative task force convened to examine the current quality of care standards for NFs, staffing patterns and standards, and the status of the labor pool to fill positions. **2001** Quality care problems are reflected by increased complaints about resident care, including accidents, care planning, responsiveness of staff, and personal hygiene.
	MI	**1999** Often the call light buttons are placed out of reach by nursing personnel, but most often staff do not respond in a timely manner. **Recommendation:** Increased staffing to meet resident needs, staff must respond in a timely and appropriate manner.
	MS	**2001** Overall neglect of basic resident needs seems to be increasing. Residents are often left in soiled diapers and have difficulty getting assistance when they require it. Non-ambulatory residents are left sitting or laying in bed for long periods of time because of insufficient staff.
	NH	**2000** Resident falls, with and without serious injury, have increased dramatically. Many such incidents occur due to inadequate supervision by staff and excessive delays in responding to residents' needs or calls for assistance due to inadequate staffing levels.
	OH	**2000** Accidents, call lights unanswered, lack of personal hygiene, inadequate care plans, and symptoms unattended can be directly linked to the lack of staff.
Medications	**CO**	**2001** Medication administration issues. See Insufficient Staff.
	IL	**2001** High number of complaints concerning medication problems. See Staffing: Job Related: Insufficient Staff.
	MD	**2001** Issues in ALFs include medication management.
	MI	**1999** Insufficient and overworked staff contribute to problems with medications. **Action:** Explain to residents and relatives that they have a right to participate in care conferences, to question anyone administering medications or the doctor about concerns, and to refuse medication (especially when it is incorrectly given).
	OR	**2000** Numerous community-based facilities are failing to consistently provide medications safely and accurately; errors can be life threatening. The need for assistance with medication management is one reason individuals move into facilities. Unlicensed and frequently inadequately trained staff are responsible for implementing a complex system. Staff should be knowledgeable of potential side effects that can rob residents of quality of life as often complex combinations of medications are changed. The licensing agency has been working with provider representatives to identify “best practices”. See Staffing: Job Related: Staff Lack Training.
	UT	**2000** There are still problems in ALFs with medication administration.

Accidents	**CO**	**2001** Improper handling of residents/accidents. See Insufficient Staff.
	IL	**2001** High number of complaints concerning accidents, improper handling. See Staffing: Job Related: Insufficient Staff.
	LA	**2000** Complaints included rough handling by aides; falls; a resident dropped during transfer; and unexplained bruises. A facility is required to keep the environment as free of hazards as possible and to thoroughly assess the reasons behind a fall and make adjustments. Falls are not entirely preventable, and some efforts to prevent them, such as the use of restraints, are often harmful or even fatal. **Recommendation:** Timely assistance, adequate staffing, staff training, and supervision are essential.
	MD	**1999** Cases reported included resident-to-resident abuse, falls, response times, and other categories, have raised serious concerns about the quality of care. A legislative task force convened to examine the current quality of care standards for NFs, staffing patterns and standards, and the status of the labor pool to fill positions. **2001** Quality care problems are reflected by increased complaints about resident care, including accidents, care planning, responsiveness of staff, and personal hygiene.
	MI	**1999** Constant turnover in competency evaluated nursing aides (CENAs), along with a shortage of properly trained staff contributes to accidents and improper handling.
	NH	**2000** Resident falls, with and without serious injury, have increased dramatically. Many such incidents due to inadequate supervision and excessive delays in responding to residents' needs or calls for assistance due to inadequate staffing levels.
	OH	**2000** Accidents, call lights unanswered, lack of personal hygiene, inadequate care plans, and symptoms unattended can be directly linked to the lack of staff.
Hygiene	**CO**	**2001** Personal hygiene, including oral hygiene is inadequate/inconsistent. See Insufficient Staff
	IL	**2001** High number of complaints concerning personal hygiene issues. See Staffing: Job Related: Insufficient Staff.
	LA	**2000** Complaints included residents left wet or soiled with feces; fingers and toenails not trimmed, baths not given and oral hygiene not provided. Personal hygiene impacts both the resident's dignity and health. Staff are required to assist residents with basic grooming - hair, nails, and teeth which is all too often left undone.
	MD	**2001** Quality care problems are reflected by increased complaints about resident care, including accidents, care planning, responsiveness of staff, and personal hygiene.
	MI	**1999** Poor Personal/Oral Hygiene-Barriers are staff turnover, short staffing and poorly trained aides. **Action:** Offer in-services that teaches that this is also a dignity issue. Encourage facilities to offer continuous in-services on good hygiene practices.
	OH	**1999** More frequent complaints in RCFs about personal hygiene, staff shortages and inadequate or a failure to follow care plans **2000** Accidents, call lights unanswered, lack of personal hygiene, inadequate care plans, and symptoms unattended can be directly linked to the lack of staff.
	TN	**1999** Continued and possibly increased complaints related to basic needs of residents, including lack of proper hygiene care.
Care Planning	**CO**	**2000** Barriers to appropriate wheel chair seating include poor wheelchair assessments. See Access to Facilities and Services: Access to Services: Special Needs **2001** Proper assessment and care planning has not occurred. See Insufficient Staff
	GA	**2000&2001 Recommendation:** NFs more adequately assess the MH needs of their residents and provide appropriate treatment.
	IL	**2001** High number of complaints concerning inadequate or unimplemented care plans. See Staffing: Job Related: Insufficient Staff.
	LA	**2000** See Accidents. A facility is required to thoroughly assess the reasons behind a fall and make adjustments such as medication changes or rehabilitation. Falls are not entirely preventable, and some efforts to prevent them, such as the use of restraints, are often harmful or even fatal.

Care Planning (cont.)	**MA**	**1999** Facility failure to adequately plan or follow care plan for residents with 'behavorial problems'; those identified as 'non-compliant' or 'uncooperative'. **2000** Increasing numbers of younger mentally ill residents on the same unit as elder residents, with need for different approaches in activities, staff interactions.
	MD	**2001** Quality care problems are reflected by increased complaints about resident care, including accidents, care planning, responsiveness of staff, and personal hygiene.
	MI	**1999** Assessments Incomplete & Care Plans Not Followed- The initial admission and subsequent assessments often do not contain family member or actual resident input or input from outside agencies with developed relationships to individual. Care plan goals may not be appropriate or attainable See Access to Facilities and Services: Transfer and Discharge: Alleged Behavior Problem **Action:** Developed and distribute a 'Fact Sheet'. Do presentations and talk with callers about residents' right to proper care, to voice concerns and to be involved in care planning. See Symptoms Unattended **2000** See Access to Facilities and Services: Access to Services: Dementia/Mental Illness
	MN	**1999** To avoid potential fines for side rail use, many facilities took away all side rails without doing the required resident assessments.
	OH	**1999** More frequent complaints in RCFs about personal hygiene, staff shortages and inadequate or a failure to follow care plans **2000** Accidents, call lights unanswered, lack of personal hygiene, inadequate care plans, and symptoms unattended can be directly linked to the lack of staff. **2001** See Access to Facilities and Services: Transfer and Discharge: Alleged Behavior Problem
Staff Background Checks/Screening		
	CO	**2001** Staff turn-over, abuser moving from one facility to another before proper investigation
	CT	**2000** Criminal background checks of licensed/certified NH staff, especially direct care staff. **Recommendation:** Establish more stringent guidelines, which must include direct care staff furnished by temporary and nursing pool agencies.
	HI	**1999 Recommendation:** Criminal history background checks of all employees and volunteers working with dependent adults. There is a growing coalition of supporters for this, but advocates for ex-convicts complain many women who are attracted to care giver positions will be denied second chance.
	MD	**1999/2000/2001 Action:** Work with legislators, stakeholders, and the public to support an expanded criminal background check requirement.
	NC	**2001** State repealed previously passed law which required national criminal background checks, and referred issue to legislative study commission because the state needs an agency able to receive FBI information per their requirements.
General Issue: Residents Rights		
General Rights		
	AR	**2001 Action:** Inform families about resident rights by working with family councils; however, councils fail when a family member's resident dies and interest wanes.
	CA	**2001** LTC facilities know what resident rights are, however, they do not enforce them. **Recommendation:** Develop training video for facility staff. Legislation that clarifies elder rights and increases the penalties for abuse. Greater enforcement efforts. Public media campaign, including educational component on LTCOP website.
	DC	**2000** The health department is reluctant to impose fines or penalties on providers or close down unsafe homes for violations of housing codes, licensing regulations and residents' rights. **Recommendation:** See Enforcement: Survey Related: Lenient/Inadequate Enforcement
	IL	**2001** High number of complaints concerning confinement in facility against resident's will. See Staffing: Job Related: Insufficient Staff.

General Rights (cont.)	**LA**	**2000** Complaints included being forced to rise and retire in accordance with the facility's schedule, not being allowed to eat in their own rooms, limits on choice in attire, and problems with smoking. The resident has the right to reside and receive services with reasonable accommodation of individual needs and preferences. Choices, preferences, and even the wish to exercise choice, may change from day to day or over time, so residents should be continually asked about their preferences.
	WA	**1999&2000 Action:** Chaired a task force to review the LTC service system and recommend improvements. Issues included poor wages for providers, inadequate choices for in-home and residential care, resident rights protection, and the balance between safety and consumer choice/preference. **2000** Residents have no voice in requesting consultation or developing new facility systems. **Action:** Worked to obtain legislation that would give residents a voice. **Recommendation:** Require that residents have a voice in requesting consultation and participating with consultants to improve their own quality of life and care.
Culture Change	**CA**	**2001** Services, environments, and approaches need to be tailored to the resident. Facilities need to be more home and community-like. **Recommendation:** Greater alignment with the Pioneer Movement. Education, training, and incentive programs. Legislation that requires systematic change.
	IL	**1999 Action:** Shared national 'Pioneering Approaches' with LTCO and facility staff. Provided workshops on how NH culture change can be implemented. Ideas included permanent direct care assignment, recognizing smaller communities within large facilities, which resulted in increased resident direction of their own care and therefore greater satisfaction in services. **2000** See Staffing: Job Related: Low Wages/Benefits **2001 Action:** Continued to sponsor nationally known Pioneers to speak to facility staff about initiatives to "normalize" life in facilities. Regional LTCO convened meetings of area providers to discuss Pioneer/culture change practices which they have or would like to implement.
	LA	**2001 Recommendation:** Ensure models of care that make NHs better places to live and to work. See Staffing: Job Related: Insufficient Staff
	MI	**1999 Action:** Encourage facilities to embrace and practice the Eden Alternative **2000** See Patient Care: Quality
	NC	**1999** Multiple complaints regarding lack of staff or inconsistent staffing. **Action:** Exploring ways to bring in the cultural change movement. **2000** Multiple complaints that resident care is not resident centered. **Action:** Worked with broad coalition on conferences specifically about culture change and how it can be implemented to improve the lives of residents and staff alike.
	NH	**1999** See Staffing: Job Related: Insufficient Staff **Recommendation:** Work toward culture change **2000 Recommendation:** Culture Change initiatives to ease the direct care workforce crisis and the quality of life for residents. Culture Change initiatives currently emerging within the state also hold potential for providing opportunities for direct care-givers to develop expertise in the area of dementia care.
	WA	**1999 Action:** Held a 'Best Practices' conference primarily aimed at NH providers; developed with provider associations and innovative facilities and resident and citizen advocacy groups. Plan further one day conferences aimed at improving working conditions to help reduce turn-over while promoting best care practices.
Confiden-tiality	**WA**	**1999** State Attorney General, Medicaid Fraud Unit gave reporters confidential information containing the names of victims of abuse, their medical records, and the names of complainants and witnesses. **Action:** Sent letter of complaint to the state and a copy to HCFA regional office. **Result:** An OIG investigation and clarification that under state law such releases are illegal. Further newspaper requests for release of MFCU information have been denied by the state.
Dignity	**CA**	**2001** LTCO staff/volunteers lack training in diversity and cultural issues necessary for maintaining the dignity and meeting the needs of residents. **Recommendation:** Develop task force, pilot project on best practices, and educational and resource materials for regional programs. Integrate a cultural competency unit into core curriculum for LTCO coordinator and volunteer training.

Dignity (cont.)	**CO**	**2001** Residents not being treated with respect and dignity. **Recommendation:** Staff training in the area of Residents Rights
	IL	**2001** High number of complaints concerning dignity issues. See Staffing: Job Related: Insufficient Staff.
	LA	**2000** Failure to treat with dignity/respect; staff attitudes. See Staffing: Job Related: Insufficient Staff and Staff Lack Training and Patient Care: Quality: Toileting/Incontinence and Hygiene.
	MI	**1999** All the issues noted under Patient Care and Residents Rights are related to resident dignity. **Action:** Offer in-services teaching that personal/oral hygiene is also a dignity issue. Provide community education and in-services to LTC employees. Promote, assist and provide support to establish and perpetuate resident and family councils in all facilities. Encourage facilities to embrace and practice the 'Eden Alternative.'
	OH	**2001** Complaints regarding dignity and respect remain high; they are likely directly related to the staffing ratios in facilities.
Consumer Empower-ment	**IL**	**2001** Understanding caregiver responsibilities for people in LTC facilities. **Recommendation:** A formal statement from AoA recognizing residents' family members as caregivers with need for information about available services, assistance to gain access to the services, individual counseling, organization of support groups, and training to caregivers to assist them in making decisions and solving problems relating to their caregiving roles; recognizing the LTCOP to be the allowable provider of this service. A few AAAs have recognized and awarded caregiver dollars to LTCOPs. To expand this practice Regional LTCOPs are presenting their successes with family council development to the aging network in hopes of obtaining additional caregiver dollars.
	MD	**2001 Action:** See Patient Care: Quality
Voting	**HI**	**1999** Voting in national and local elections in NFs is not conducted consistently throughout the state. There are differences in use of outside volunteers versus staff and registration with the facility's district versus original home district. Residents are not aware that their signatures on registration forms and the ballot must match. **Action:** Working with Board of Elections to create guidelines for voting in NFs so there is more uniformity.
Representation		
	MD	**2000&2001** Increasing need by residents and family members for legal assistance regarding financial concerns, abuse and neglect, enacting advance directives, contract issues, Medicaid discrimination, and representation in litigation.
	NM	**2001 Action:** Partnered with elder law programs and private attorneys to create the NH Litigation Task Force to ensure expedient referral to an attorney when requested by a resident or family member wanting to pursue litigation with regard to a complaint or injury.
Guardian/ Power of Attorney Issues	**CO**	**1999** Some involuntary transfers involved nonpayment due to financial exploitation by a conservator. See Access to Facilities: Transfer and Discharge: Non-payment **2000** Many persons and facilities misuse powers of attorney to take away residents' rights. Facility staff, professionals and family members lack understanding of the limitations, responsibilities and duties of the agent under a power of attorney to fulfill the wishes of the principal and to not act on behalf of the resident when the resident is capable of making his or her own decision unless given authority to do so by the resident. **Recommendation:** Train facility staff, professionals and family members on powers of attorney documents. Legal assistance is needed to revoke powers of attorney documents when they are misused.
	MD	**2000&2001** Increasing need by residents and family members for legal assistance regarding private guardianship issues and enacting a Power of Attorney.

Guardian/ Power of Attorney Issues (cont.)	**MO**	**1999** Guardians and public administrators sometimes do not respect resident rights. The barriers include difficulty in reaching all guardians, getting judges to understand the personal needs allowance, and coming up with a simple, yet effective, way to educate people. **Action:** Working on a document that explains the principles and standards for guardians. **2000** Inappropriate guardianships; Public Administrators (elected county officials) who receive all or part of the Personal Needs Allowance; and guardians who are unaware of or do not protect the residents state and federal rights.
	OH	**2000&2001** Access to Facilities and Services: Transfer and Discharge: Non-payment
	OR	**1999 Action:** Participated in developing guardianship laws. One outlines fiduciary conflict of interest and requires disclosures by professional fiduciaries. See Ombudsman Program: Visibility/Role: Notice of Discharges/Transfers
	RI	**1999** Guardianship/Legal
	WV	**1999** Misuse or overextension of authority by legal representatives who do not consider the rights and opinions of the resident and, for matters of convenience, expediency, or just vindictiveness, make decisions for residents that residents are capable of making themselves. **Recommendation:** Rewrite state laws to more clearly demand that a legal representative can not go beyond what a resident is capable of doing for themselves. Better educate guardians about residents' rights.
Neglect/Abuse		
	CA	**1999** Abuse of residents in LTC facilities remains a problem statewide. The state increased the LTCO mandated reporting responsibilities. This legislative mandate encompasses many state agencies, programs, and providers. **Action:** Conducted significant training of aging network staff. **Recommendation:** Align perspective laws of conflict and confidentiality to serve the best interests of residents. Further training is necessary on the increased elder abuse mandates. **2001** Elder Abuse is under-reported in LTC facilities due to misunderstanding of mandatory reporting laws, fear of retaliation, and other factors. **Action:** Updating elder abuse section of core training curriculum for LTCO and volunteers. Coordinators attend local trainings and work with local community **Recommendation:** Develop task force to recommend intervention strategies. Add elder abuse training on LTCOP web site. Legislation that clarifies reporting requirements and increases penalties for failure to report. Increased prosecution for failure to report. Attorney General's Office produced and will distribute a training video for providers on mandatory reporting.
	CO	**2001** Abuser move from one facility to another before proper investigation. Staff unaware of what constitutes abuse. See Staffing: Job Related: Insufficient Staff. **Recommendation:** All staff receive training in what constitutes abuse and how to report it.
	DC	**2000** See Patient Care: Quality
	GA	**2000&2001** Law enforcement and prosecutors are often unaware of elder abuse in communities and facilities or mistakenly believe such problems are a regulatory concern, not a criminal matter. **Recommendation:** Training and resources to enable law enforcement officers and prosecutors to adequately respond to criminal activity against elders and facility residents and to raise their awareness of LTC issues.
	MA	**2001** Increase of younger brain injured, behavioral and or MH residents. One national chain contracted with a neighboring state to provide 'behavioral services' through the 'criminal diversion program'. This has resulted in a significant problem with resident to resident physical and sexual abuse issues.

Neglect/ Abuse (cont.)	**MD**	**1999/2000/2001** Federal mandatory versus state voluntary reporting requirements is a continuing challenge. See Access to Facilities and Services: Access to Services: Young Adults **1999** Continued abuse, neglect, and exploitation in both institutional and community-based settings. NF cases including resident-to-resident abuse raised serious concerns about the quality of care. Complaints from ALFs relate to resident care/neglect. A state-wide coalition has a toll-free hot line for reporting abuse or to provide information, conducts training and certification for targeted professionals, and develops public awareness material and special events. **2000** Abuse continues in ALFs in part due to lack of clearly defined responsibilities for identified agencies and limited oversight of many facilities, including mandatory v. voluntary reporting of abuse cases. **Recommendation:** Continued in-service training for professionals and paraprofessionals and educational sessions to the public on abuse. Legislation such as expanded criminal background check requirement, electronic monitoring in NFs, and the NH initiative bills. **2001** Case severity seems more serious, including, for example, resident death. There was a slight increase in ALF abuse complaints and an increase in NF resident-to-resident abuse complaints. **Action:** Work with state agencies and others to develop training sessions on recognizing, reporting, and investigating abuse cases.
	NC	**2001** High rate of nonsubstantiated complaints of abuse, neglect and exploitation. Rules are written to screen out potential victims rather than screen them in.
	NJ	**1999/2000/2001** As facilities provide more specialized care, reports arise of abuse and neglect that used to be limited to acute care hospitals.
	NM	**1999** Residents experience horrendous neglect. The facility may have sanctions levied, but care doesn't improve, since it costs less to pay (or fight) sanctions than to provide good care. **Action:** Cooperating in a task force to increase legal referral of abuse, neglect and exploitation cases when desired by residents and/or their families.
	NV	**2000 Action:** Provide regular educational training to facility staff on mandatory elder abuse reporting requirements, residents' rights, access to records and role as advocates. **Result:** Extensive training and consultation on mandatory elder abuse reporting requirements resulted in an increase of timely elder abuse reports and facilities have improved handling of internal investigations on abuse issues and use of more immediate preventive measures to protect residents.
	NY	**2000** Increasing evidence of lack of critical staff and care with resulting incidences of abuse and neglect.
Restraints	**LA**	**2000** Besides psychological and physiological problems, restraints can lead to serious physical injuries up to and including death. use of a lap or vest restraint may lead the resident to pull a wheelchair over on themselves. Residents have injured themselves severely and even strangled on bedrails. See Patient Care: Quality: Accidents and Care Planning **Recommendation:** Assisting residents in a timely fashion is critical. Adequate staffing, staff training, and supervision are essential.
	MN	**1999** To avoid potential fines, many facilities took away all side rails and told residents and family members that this was due to the health department. Many family members complained, which resulted in a new state law clarifying the conditions under which a side rail can be used and identifying 'fear of falling' as a legitimate medical reason. This may be incompatible with federal restraint law or rules. **Action:** Worked with the state on consumer and provider education on restraint reduction efforts, including development of a resource published using funds from civil penalties. Provided consumer training and educated families on all possible restraints.
	NH	**2000** There are strong indications that restraint use is a frequent practice because there are insufficient staff to provide appropriate activities and monitor those residents with exit-seeking behaviors or who enter unsafe areas of the facility. See Staffing: Job Related: Insufficient Staff

Restraints (cont.)	**PA**	**1999** Facilities which in 1996 had 23% of residents physically restrained, by 1999 had only 2% physically restrained or were restraint-free. A restraint-free facility highlighted in the news said that eliminating restraint use has 'led to happier residents and was a major factor in reducing the annual employee turnover rate from about 30% to 16%'. Despite all this, much confusion remains among providers, residents and families. Families complain that if they request that a resident be restrained, the facility response is 'the state will not let us use restraints', instead of providing information on the conditions for use of restraints and reasons they are inappropriate for the resident. **Action:** Provide information and education directly to consumers and families, which may encourage resistant providers to approach restraint reduction in a positive way. Had presentations by recognized authorities citing restraint-free facilities and have utilized them for technical assistance on restraint reduction.
	RI	**1999** Family education, especially regarding restraints
Financial Issues		
Personal Needs Allowance	**CT**	**2000** Residents are not afforded the minimum finances to purchase necessary personal items not covered under their per-diem rate. Residents list increase in personal needs allowance under Medicaid benefits among their top priorities. **Recommendation:** Increase the current $52.00 per month to $100.00 per month.
	HI	**1999** Personal Needs Allowance is supposed to be for residents use on items such as clothes, long distance phone calls, stamps, gifts; however, several homes charge residents for transportation for doctor's visits, basic toiletries like tooth paste, soap and shampoo, toilet paper, laundry, etc. State rules don't preclude this. **Action:** Organized ad hoc committee to look into this. **Recommendation:** Above items should be clearly stated in writing in the contracts as part of room and board rate.
	ID	**1999 Action:** Attempting to get rule change to increase the personal needs allowance for NH residents on Medicaid. (PNA is currently $30mo.)
	MI	**1999** Personal Funds Mismanaged- Often individual monies are not segregated but kept in a joint account (often a simple envelope). **Recommendation:**. Develop new legislation regarding accounting and the bookkeeping pertinent to resident funds; require daily accounting to control the flow of cash.
	MO	**1999** difficulty getting judges to understand the personal needs allowance **2000** Public Administrators (elected county officials) who receive all or part of the Personal Needs Allowance.
Lost Property, Theft, Exploitation	**CO**	**1999** Some involuntary transfers involved nonpayment due to financial exploitation by a conservator. See Access to Facilities: Transfer and Discharge: Non-payment
	HI	**1999** APS has refused to investigate 'financial exploitation' by family members of NF residents. Social security or pension checks or other assets not owed to the facility may be misappropriated by family members and only APS has the statutory responsibility and power to protect the resident's assets while an investigation is conducted by APS. **Action:** Brought this problem to state legislature, and ad hoc committee has been formed to look into this issue.
	IL	**2001** High number of complaints concerning personal property lost, stolen, used by others, or destroyed. See Staffing: Job Related: Insufficient Staff.
	KY	**1999** Exploitation **Action:** Working with state Attorney General and APS.
	LA	**2000** Personal property lost, stolen, used by others, or destroyed; including dentures, eyeglasses, hearing aids, clothing, money and personal mementos. The loss of personal aid items can affect the ability to function independently and they are inadequately or not at all covered by Medicaid. Loss of clothing or personal mementos can impart hopelessness, anger and insecurity. **Recommendation:** Facilities should establish and prominently post policies and investigative procedures for loss and theft; mark and inventory items; provide lockable space for residents; and regularly training staff on the importance of personal items to residents. Family members and residents can have dentures, glasses and hearing aides engraved; ask that all new items be added to the inventory; and report missing items promptly.

Lost Property, Theft, Exploitation (cont.)	**MD**	**1999** Financial exploitation in institutions and the community, which is difficult to uncover and resolve. See Neglect/Abuse: Abuse **2000** Financial exploitation in institutions and the community, which is difficult to uncover and resolve. The State Unit on Aging applied for a state grant to fund Project SAFE (Stop Adult Financial Exploitation). A new law sometimes waives confidentiality requirements to allow fiduciary institution personnel to report suspected abuse.
	MI	**1999** Personal Property Lost/Stolen/Used by Others or Destroyed- Resident frustration, when other residents wear their clothing or have their personal property, lowers quality of life; contributes to depression, acting out; and can lead to resident to resident altercations. Also see Personal Needs Allowance **2001** Financial exploitation of LTC consumers by family or facility staff.
	OR	**1999 Action:** Participated in developing a guardianship law which outlines fiduciary conflict of interest and requires disclosures by professional fiduciaries.
	RI	**1999** Financial issues/personal funds, non-payment etc. **2000** There are few regulations for ALFs or RCFs, which leaves administrators and owners at liberty to financially exploit the residents.
Due Process (also see Access to Facilities and Services: Transfer and Discharge: Procedures)		
	NC	**1999** Licensure agency unwilling to address certain discharges as retribution for complaints under residents' rights. **Action:** See Access to Facilities and Services: Transfer and Discharge: Assisted Living, B&C, Similar **2000** Industry and regulatory agencies not educated on new law/regulation entitling ACH residents to 30-day discharge notice and the right to appeal.
	NH	**1999** Residents are not afforded access to a viable 'fair mechanism' for hearing appeals regarding involuntary transfers or discharges, as required by law. Federal law requires that the same hearing system be available to all residents of Medicare/Medicaid certified facilities, regardless of their source of payment.
General Issue: Ombudsman Program		
Program Support		
Financial	**CA**	**1999** Inadequate resources to meet federal and state mandates. Many aging programs were underfunded, producing competition for scarce resources. Volunteer-based programs were perceived as able to operate on in-kind resources. **Action:** With support, requested added money. **Result:** Received a $2 million increase from state based on the IOM Study performance indicator of one full-time equivalent to 2,000 beds. **Recommendation:** Additional documentation such as New Hampshire formula defining the value of volunteer labor should also be incorporated into justification of increased resources from State Legislatures. **2001** In light of increasing complaints, increased funding is needed for development and program effectiveness. Also see Political Issues and Need Legislative Support.
	HI	**1999** Legislature appropriated monies for full-time Volunteer Coordinator and clerical support staff. **Action:** Completed job description and now awaiting final approval before filling position and recruiting volunteers. This is especially important because facilities and residential care homes are spread over 6 islands.
	ID	**2001 Action:** Implementing a new reporting system to help track the effect of Medicaid waiver changes on complaint activity and the already stretched LTCOP dollars.

Financial (cont.)	**IL**	**2001** Understanding caregiver responsibilities for people in LTC facilities. **Recommendation:** A formal statement from AoA recognizing residents' family members as caregivers with need for information about available services, assistance to gain access to the services, individual counseling, organization of support groups, and training to caregivers to assist them in making decisions and solving problems relating to their caregiving roles; recognizing the LTCOP to be the allowable provider of this service. A few AAAs have recognized and awarded caregiver dollars to LTCOPs. To expand this practice Regional LTCOPs are presenting their successes with family council development to the aging network in hopes of obtaining additional caregiver dollars.
	MD	**1999/2000/2001** See Insufficient Staffing/Turnover
	MI	**2001** Transition of LTCOP from one agency to another, leaving several local programs under original agency without funding received via state LTCOP.
	NE	**2000** Barriers to expanding the program include lack of funding and state-mandated limits on personnel. **Action:** Set up regional programs in two parts of the state and trained volunteers.
	NY	**2000** Coverage is not sufficient in several areas and the primary barrier is limited funding, which is needed to increase the numbers volunteers and expand the hours of local Coordinators, and to upgrade their technological support system to allow more time with residents and improve communication within the program. It is also imperative to pay travel and out-of-pocket expenses of volunteers, many of whom would be unable to volunteer otherwise. **Result:** The state provided new substantive State funding, which was used to help expand Coordinator and Volunteer hours and begin upgrading the technological support. Some local programs purchased computers and other equipment; others provided stipends for volunteer transportation costs.
	PR	**2000** Experiencing staffing problems, mainly due to low salaries. High turn over has affected program efficiency, since visits to facilities and complaint follow up depend on having sufficient properly trained and motivated LTCO representatives.
	TN	**2000** The computer reporting system crashed, caused problems with input and the acceptance of data, and could not interface with the district programs. This caused long delays in compilation of information and, sometimes, district data had to be manually entered into NORS. **Recommendation:** Obtain a more “user friendly” system.
	UT	**2000** No additional state funding since 1993 and increase in complaints of about 400%. With the increase in complaints and complaints and cases getting more complicated and time consuming, regular facility visits have gone down and the program has become very reactive with less time for prevention such as education, training, work on laws ,etc. **Action:** Successfully recruited and trained volunteers. The aging director provided a half-time support person to help at the state office. **2001** Lack of funding has resulted in little time for education, training, systemic advocacy and regular facility visits.
	WA	**1999** Previous funding enabled the LTCOP to be locally accessible in all parts of the State, but an additional $500,000 would be needed to meet the Advisory Board goal of one-half FTE staff person per 2,000 beds in each region. **Action:** Advisory board worked to educate local legislators. **Result:** Secured $250,000 from the legislature. State law changed to allow volunteers to investigate complaints.
Insufficient Staffing/ Turnover	**CA**	**2000** Program review found high turnover (half the local Coordinators had been there less than two years). **Action:** Newer Coordinators were given special training each quarter. **Result:** The Coordinators feel more comfortable calling state analysts for technical assistance. All have stayed and developed considerable expertise; two other Coordinators were promoted.
	HI	**1999** Legislature appropriated monies for full-time Volunteer Coordinator and clerical support staff. **Action:** Completed job description and now awaiting final approval before filling position and recruiting volunteers. This is especially important because facilities and residential care homes are spread over 6 islands.

Insufficient Staffing/ Turnover (cont.)	**KY**	**2001 Action:** Involved in hearings to establish full time LTCO in all 15 districts.
	MD	**1999/2000/2001** Limited staff, program, and monetary resources to effectively respond to needs of elderly abuse victims or develop educational material and programs. **1999&2000** Inadequate staffing and monetary resources in many jurisdictions to carry out mandates in ALFs, which now include elderly housing. **2000** Legislation was passed to establish a minimum staffing pattern for the LTCOP related to NFs, which will be fully funded by FY03. **2001** LTCOP allocated second year funding under the new initiative; however, the current economic downturn threatens the full funding in the third year.
	MI	**2001** Recruitment and retention of volunteers
	NC	**2001** LTCOP position reductions at the state level.
	NE	**2000** Barriers to program expansion include lack of funding and state-mandated limits on personnel. **Action:** Set up regional programs in two parts of the state and trained volunteers.
	NH	**2000** There exists a generally low level of awareness and utilization of the intervention, education, and advocacy services of the LTCOP among residents, their families and community elder advocates. There are limited human resources to conduct outreach and informational sessions for consumers.
	NY	**2000** Coverage is not sufficient in several areas and the primary barrier is limited funding, which is needed to increase the numbers volunteers and expand the hours of local Coordinators, and to upgrade their technological support system to allow more time with residents and improve communication within the program. It is also imperative to pay travel and out-of-pocket expenses of volunteers, many of whom would be unable to volunteer otherwise. **Result:** The state provided new substantive State funding, which was used to help expand Coordinator and Volunteer hours and begin upgrading the technological support. Some local programs purchased computers and other equipment; others provided stipends for volunteer transportation costs.
	PA	**1999** Seek to have all Area Agencies on Aging using volunteers to supplement paid staff. **Result:** Volunteer LTCO significantly expanded the outreach and accessibility to consumers in facilities and the community. **2000** Efforts to enhance the use of volunteers continued. **Action:** Conducted local and statewide trainings. Contracted with the state Association of AAA for Regional Volunteer Coordinators to provide technical assistance, recruitment, orientation, training, and support in management to AAA staff and volunteers. **Result:** All AAAs participate and recruit volunteers.
	PR	**2000** Experiencing staffing problems, mainly due to low salaries. High turn over has affected program efficiency, since visits to facilities and complaint follow up depend on having sufficient properly trained and motivated LTCO representatives. **2001** Continue to experience problems in recruitment of volunteers, especially in local programs with many facilities.
	UT	**2000** No additional state funding since 1993 and increase in complaints of about 400%. With the increase in complaints and complaints and cases getting more complicated and time consuming, regular facility visits have gone down and the program has become very reactive with less time for prevention such as education, training, work on laws ,etc. **Action:** Successfully recruited and trained volunteers. The aging director provided a half-time support person to help at the state office. **2001** Volunteers don't usually last more than a year.
	WA	**1999** Previous funding enabled the LTCOP to be locally accessible in all parts of the State, but an additional $500,000 would be needed to meet the Advisory Board goal of one-half FTE staff person per 2,000 beds in each region. **Action:** Advisory board worked to educate local legislators. **Result:** Secured $250,000 from the legislature. State law changed to allow volunteers to investigate complaints.

Workload Issues	**CA**	**2001** In light of increasing complaints, increased funding is needed for development and program effectiveness
	ID	**2000** Frequent, regular visits to 100% of facilities and availability to residents was becoming less of a reality, due to the increasing work load. Our program always investigated complaints regarding all elderly citizens in the community. To improve service to facilities, requirements were changed to only handle LTC related complaints, stop regular visits to senior centers, and increase the regular visitation to ALFs/RCFs.
	NM	**2001 Action:** Volunteer work on complaints is more accurately counted due to a new visit summary sheet which allows them to check off uncomplicated complaints resolved during a visit instead of writing a lengthy case report on each complaint.
	UT	**2000** No additional state funding since 1993 and increase in complaints of about 400%. With the increase in complaints and complaints and cases getting more complicated and time consuming, regular facility visits have gone down and the program has become very reactive with less time for prevention such as education, training, work on laws ,etc. **Action:** Successfully recruited and trained volunteers. The aging director provided a half-time support person to help at the state office.
Computer System Related	**OH**	**2001** The older system was not time-efficient; data could not be customized to LTCOP needs; documentation of activities was not contemporaneous; data entry errors were difficult to correct; not all NORS required data was tracked; the system was not centralized and local maintenance was required. **Action:** A consultant developed a new system incorporating electronic complaint handling, general information, advocacy activities, NORS information, National Outcome Measures, and State Office quality measures. A user's guide and reporting instructions were written and training conducted at the regional level.
Training Related	**IL**	**2001** Training varied with the 17 regional programs training their staff using a state LTCOP developed manual. State funding and staffing was inadequate to have state LTCOP provide all training. **Action:** Revised the basic and advanced training materials. Regional LTCOPs continue to do basic training; state LTCOP does the advanced training in 4-6 locations across the state and pays travel and lodging for trainees living more than 30 miles from the training site.
Political Issues	**CA**	**2001** Too little system advocacy is being done by the State and local LTCOPs. Resident advocacy is the priority, funding is insufficient as is, association of local LTCO is not focussed, and the State LTCOP is under State Unit on Aging. **Recommendation:** Increase budget. Develop task force to study system advocacy and develop strategic plan. Training in advocacy and social marketing. Provide local LTCO association with support for organizational development.
	GA	**2001 Action:** The LTCOP became administratively attached to the Division of Aging Services in order to maximize the effectiveness of the program and enhance its ability to advocate for residents, while minimizing conflicts of interest. A state-level Advisory Committee will provide opportunities to receive consumer and community perspectives on program operations and priorities.
	IL	**2001** Area Agencies tend to interpret the LTCOP structure and administration the same as other services under the Older Americans Act, leading to inconsistencies. **Action:** Hired a national expert to facilitate review and update of the current standards in order to convert to a more consistent, direct advocacy services program.
	NC	**1999** Had not been addressing issue advocacy on a systemic level due to: conflicting roles as a state program voicing the state's views vs. a federal program with a mandate to advocate on a systems level. Lacking knowledge, policies, and procedures about the mandated role and responsibility. Resistance to change. **Action:** Revising policies and procedures to include issue advocacy both in standards and general policy after receiving an interpretation from the Attorney General's office reiterating the Program's responsibilities under federal law.
	OR	**2001** A proposed bill to create a Legislative Ombudsman would have transformed the LTCOP from an agency that works with residents in LTC facilities into one that monitors other agencies' responses to resident complaints. Following AoA and citizen advocacy groups comments, the bill was changed to leave the LTCOP as is.

Political Issues (cont.)	**PR**	**1999** Area Agency reorganization resulted in significant change to Local Programs, including areas covered by programs, recruitment and training of paid and volunteer personnel and finding new offices for local Programs. By the second semester, all local programs were in place and all but one LTCO were recruited and trained.
Need Legislative Support	**CA**	**2001** LTCO have legal council, but no legal representation in court proceedings when complaints are challenged in court. **Recommendation:** Legislation requiring legal representation for LTCOPs. Increased Ombudsman budget.
	HI	**1999** Upon recommendation of Attorney General, statute and policies and procedures for LTCOP need to be strengthened. **Action:** EOA hired a consultant to assist in drafting of administrative rules, much borrowed from other states, in strengthening our program.
	IL	**1999** Under enforcement provisions from OBRA 87, hospital based SNF/NF units are required to post the name, address and telephone number of the State LTCO, but LTCO did not have representation and indemnification authority within these units under state law and thus could not serve these residents. **Action:** Proposed legislation which was passed to expand the state's LTC facility definition to include these units. Sent a letter to them notifying them of the change and including the LTCOP poster and general brochure.
	MD	**2001** Complaint investigations impeded by issues of access to records, staff and facilities. **Recommendation:** Strengthen state statutes; educate facility administration.
	NM	**2001 Action:** Sent letters to legislators when facilities in their districts received a citation or violation of significant magnitude, a deficiency-free survey, or a survey of unusual concern. Legislators now show a greater recognition, understanding and support of the LTCOP.
Quality Measures	**NM**	**2000** The State identified performance measures for the Program and will initiate a performance-based budget in FY 2002. **Action:** Got a grant to develop and implement performance measures, including one output and two outcome measures for the Program. These measures will be a major part of the quality assurance and budgeting process in future years and will provide a method for comparing work from year to year and for evaluating our effectiveness with residents and families. **2001** LTCOP is meeting new performance based budgeting standards based on number of complaints identified and investigated and the percent of complaints resolved. A survey of residents, family members, NH staff and service providers to assess the complaint resolution process and general conditions in LTC facilities was designed and implemented by an outside contractor. Survey results will be used to improve the complaint process and increase public awareness of the LTCOP.
Visibility/Role		
General Visibility	**MN**	**2001** Statute on housing with services providers changed to require contracts with consumers to include the LTCOP toll free number as a complaint resolution resource.
	NH	**2000** Awareness and utilization of program services among residents, families and community elder advocates, is low, even with a significant increase in calls from 1999 to 2000. Judging by the low number of reports and calls for assistance from consumers and their loved ones, it seems that residents and family members either do not know about the program or do not understand how the program can support and assist them. The LTCOP has limited resources to conduct outreach and informational sessions for consumers. Plans focus on contact with existing family councils and support groups, advocacy groups, and senior centers; expanding the volunteer corps and encouraging outreach during facility visits; redesign and broader distribution of materials; and increased appropriate contact with the legislature.
	PR	**2001** LTCOP elevated to an appointed position in the Governor's Office for Elderly Affairs, as required by state law, which increases program visibility and ranking.
Coordi-nation with	**CA**	**2001** Residents would benefit from a more coordinated approach among regulatory agencies and advocacy groups. **Recommendation:** Further development of cross reporting and coordination of cases through an interdisciplinary team approach

Licensing	**DE**	**1999** State legislation gave responsibility for abuse investigations to the survey agency, instead of LTCO unit, which will now simply track abuse complaints. **Action:** Both Divisions are establishing an intra-departmental Memorandum of Understanding to clarify responsibilities of resident protection.
	MI	**2000** Voluntary and involuntary NH closures **Action:** Requested licensing and certification to notify LTCOP as soon as they learn of a closure [successful]. Developed collaborative relationship with the agency in the lead during an "involuntary" closure. See Access to Facilities and Services: Transfer and Discharge: Closures
	PR	**2000** Outdated law and regs concerning B&C facilities and a licensing agency which has been consequently uncooperative and not open to suggestions.
Insufficient Presence in Facilities	**HI**	**1999** The state's NFs and RCFs are spread over 6 islands making it difficult to have a strong, consistent presence. Legislature appropriated monies for full-time Volunteer Coordinator and clerical support staff. **Action:** Completed job description and now awaiting final approval before filling position and recruiting volunteers.
	ID	**2000** Frequent, regular visits to 100% of facilities and availability to residents was becoming less of a reality, due to the increasing work load. Our program always investigated complaints regarding all elderly citizens in the community. To improve service to facilities, requirements were changed to only handle LTC related complaints, stop regular visits to senior centers, and increase the regular visitation to ALFs/RCFs.
	MD	**1999/2000/2001** Inadequate staffing and monetary resources in many jurisdictions to carry out mandates in ALFs, which now include elderly housing.
Role re Assisted Living/ Other populations	**CA**	**2001** State law has extended LTCOP jurisdiction to all populations in all community-based LTC facilities. **Action:** Increased work with other agencies to define and clarify jurisdictions, develop advocacy systems, and cooperate.
	CT	**2000** Call to expand program advocacy to address consumer protections and rights to ALF residents/applicants. **Recommendation:** Establish a fund to increase staff.
	MI	**2000** Receive calls for ALF information and help in addressing ALF care complaints, but the state limited the LTCOP to complaint resolution in "licensed" facilities [NHs, county medical care facilities, HFAs, hospital LTC units, AFC homes.] **Action:** Drafted an Action Sheet on ALFs. Surveyed unlicensed facilities in one county. Responded to inquiries and questions about care complaints or concerns in these facilities. See Enforcement: Related to Regulations: Assisted Living, B&C, Similar
	MN	**2001** Statute on housing with services providers changed to require contracts with consumers to include the LTCOP toll free number as a complaint resolution resource.
Education of other Profession-als	**GA**	**2000&2001** Law enforcement and prosecutors are often unaware of elder abuse in communities and facilities or mistakenly believe such problems are a regulatory concern, not a criminal matter. **Recommendation:** Training and resources to enable law enforcement officers and prosecutors to adequately respond to criminal activity against elders and facility residents and to raise their awareness of LTC issues.
	IL	**2000** Need for law enforcement officers to become specialized as Elderly Service Officers following training on how to serve seniors. **Action:** As part of a training where all aging network services are described so that officers know better how to communicate, serve or make appropriate referral with seniors, participate in session titled "Crimes in Long Term Care Facilities" The program brochure, residents' rights booklet, a publication entitled "Abuse and Neglect in the Long Term Care Setting" and a list of all regional LTCO are distributed for inclusion in their notebook for future reference.
	MD	**2000&2001** Continued abuse, neglect and exploitation in both institutional and community-based settings. Federal mandatory v. state voluntary reporting requirements of abuse cases complicates the issue. **Recommendation:** Continued in-service training of professionals and paraprofessionals and public educational sessions.
Notice of Discharges/	**MI**	**2000** The LTCOP does not receive copies of all transfer/discharge notices given to residents and does not automatically get all the hearing decisions, because such is not required. **Action:** See Access to Facilities and Services: Transfer and Discharge: Procedures

Transfers	**OR**	**1999 Action:** Participated in developing a law which, while significantly amended to limit the cost of expanded due process, revises the notice to respondents, requiring that the OLTCO receive notice of protective proceedings when there is an intent to place the protected person in a LTC facility or the proposed protected person resides in a LTC facility.